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PROPAGATING PRIVILEGE: AN ANALYSIS OF THE MARKETING AND
CONSUMPTION OF DONOR SPERM

by

MEGAN M. TESENE

Under the Direction of Wendy Simonds, PhD

ABSTRACT

As medicine, technology, science, and industry coalesce into a hybridized biomedical market, individuals are increasingly treated as customers who must pursue health by consuming products and services. It is within this context that clients of donor sperm make their donor selections. Although they make their selections as individual consumers, they are subject to powerful marketing and corporate-sponsored knowledges that promote very specific notions of health, family planning, and the ideal child. Clients of donor sperm, like most aspiring parents, want their children to be happy, healthy, and successful. Given the unique options that are available via the sperm donor market, they select characteristics and traits that will benefit their child in a society that is built upon complex intersecting systems of oppression. In this way,

clients of donor sperm attempt to pass on privileges to their children and families, often ensuring that they themselves will maintain their advantaged positions in society. The contemporary sperm banking industry serves as a platform wherein individuals and families attempt to obtain these privileges through the power of purchase. They do so consistently and predictably—adhering to dominant ideologies regarding what people and what bodies are worthy of reproduction. In purchasing a donor, they select traits of power and privilege—constructing families that embody hegemonic values regarding race, health, ability, intellect, success, and family formation.

INDEX WORDS: Donor sperm, Biomedicalization, Reproducing inequalities, White privilege, Marketing risk, Expanded carrier screening, Genetic counseling, Neoeugenics

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MEGAN M. TESENE

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

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CONSUMPTION OF DONOR SPERM

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DEDICATION

For Patricia J. Tesene, who witnessed the beginning of this journey—perhaps in all those weekly treks to Oak Park Public Library during my childhood. Gone too early, but not entirely gone, your imprint far too profound and complicated for such an absence. Always with me, as I cross this finish line, and the next.

With love,

Your daughter, Dr. Tesene

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As for my squad, my comrades in commiseration: You are everything. 3AM texts, all-day coffee-shop work sessions, and existential quandaries abound—you are my greatest cheerleaders and I'll forever be one of yours.

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LIST OF ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ARTs: Assisted Reproductive Technologies

ASRM: American Society for Reproductive Medicine

CCB: California Cryobank

DI: Donor Insemination

DNA: Deoxyribonucleic acid

FDA: Food and Drug Association

GTS: Genetic Testing Summary

HIV: Human Immunodeficiency Virus

ICSI: Intracytoplasmic Sperm Injection

NABSW: National Association of Black Social Workers

QCA: Qualitative Content Analysis

1 INTRODUCTION

*“We want to give your child
the best possible start.
Believe me,
we have enough imperfection
built in already.
Your child doesn’t need
any more additional burdens.
Keep in mind, this child is still you.
Simply, the best of you.
You could conceive
naturally a thousand times
and never get such a result.”*
—Geneticist in the 1997
Sci-Fi thriller, *Gattaca*

In an office building displaying the sign, “Pro-Creation,” a geneticist in the 1997 Sci-Fi thriller *Gattaca* advises a young couple of the benefits of creating a child from their most ideal traits—all transmitted via their respective genetic materials, which can be individually pre-selected to construct the perfect child (Niccol 1997). The benefits? A child unburdened by physical and mental disorders and diseases. A child who is healthy and intelligent with a guaranteed aptitude for success and achievement. A child who is anything but average, they are superior in every possible way to those children born via “natural” heterosexual intercourse. The parents agree; this does sound like the best path forward.

Released 22 years ago, the scene could just as well serve as a dramatization of the marketing and consumption practices within the contemporary sperm banking industry. Indeed, online sperm banks currently serve as a platform wherein aspiring parents-to-be can engage in family planning that employs a customized “consumer-choice” model. Clients use the donor selection process as a way to pre-select traits and aptitudes that they *hope* will be passed on to their progeny. Although the “science” behind the simplistic rules of inheritance that such

selections rely on may or may not be valid, clients of donor sperm make their donor selections with the hope that they can provide their children with bodies, health, physiques, and aptitudes that will ensure their success in life. Reinforcing hegemonic values regarding race, family forms, health, ability, intellect, and aptitudes for success, clients of donor sperm select donors who they believe can pass on privileges to their children in a society entrenched with complex and intersecting inequalities.

In this study, I employ both qualitative content analysis of sperm bank marketing materials and interviews with 33 women clients of donor sperm to document these practices. The fundamental purpose of this dissertation was to examine how sperm banks are marketing sperm *and* how those seeking to achieve pregnancy via donor sperm interact with and understand the donor profiles as they make their selections. My analyses focused on how various forms of inequality such as white supremacy, hetero-patriarchy, and eugenic values and practices are reproduced within the donor insemination market. This research project was also an attempt to highlight how this industry markets various forms of inequality and how consumers, in turn, respond to, reinforce, and potentially resist those efforts. Unfortunately, I find little evidence of clients of donor sperm resisting those hegemonic value systems.

Indeed, in the following pages I highlight some of the ways that clients of donor sperm acknowledge and problematize those values, yet they simultaneously employ and reproduce those values in exchange for the protections that they provide clients and their children from individual and systematic inequities. In the first article, “White Like Me: The Propagation of Privilege Among White Women,” I analyze content from interviews with 17 of the 33 interviewees as this subgroup broke from the trends identified in the extant literature which examines white women’s experiences with sperm donor selection. Whereas others have

documented how white women tend to avoid speaking about or even acknowledge the significance of race in their donor selections (Mamo 2005; Nordqvist 2012; Ryan and Moras 2016), I find that when encouraged, interviewees spoke directly about race as a system of oppression that disadvantages people of color. Despite these explicit conversations about race, I also find that white women uphold white invisibility—failing to acknowledge how they personally benefit from white supremacy and how their choices in creating racially homogenous families are an attempt to maintain their privileges in a racist, heterosexist society.

In “Risky Business: Marketing Risk and the Expansion of Genetic Screening,” I employ qualitative content analysis of sperm bank marketing materials from four online sperm banks—three commercial and one non-profit. In the study, I document how online sperm banks’ marketing of aspirational parentage is entrenched in discourses of fear, risk, and techno-scientific medical excellence. Clients are made to fear the countless risks posed by communicable and heritable diseases. Only through the application of innovative screening procedures and the dedication of scientists and medical experts—in the employ of these companies—can clients rest assured that their hopes of producing a healthy child is possible. All these efforts serve to encourage and assist clients of donor sperm in producing the best possible outcome: a healthy child who is unburdened by genetic, physical, or mental diseases and disorders. In commodifying health in this way, the sperm banking industry also commodifies the propagation of privilege, enabling those who have the ability and resources to participate in the evolving reproductive market to literally purchase the health of their child.

Finally, in “The Good, The Bad, and The Ugly: Exploring the Eugenic Implications of Sperm Donor Selectivity,” I examine interview data from all 33 respondents, identifying how, through their sperm donor selection practices, they engage in what Judith Daar (2017) calls

neoeugenics. According to Daar (2017), we have moved into a new era of eugenics where authoritative, governing bodies no longer need to enforce oppressive policies which attempt to prevent “undesirables” from procreating. Rather, with the vast expansion of reproductive science, medicine, and technologies, eugenic practices are more likely to be carried out at the individual level. In the article, I document how interviewees view the donor selection process as a way to stack the deck in their child’s favor—potentially providing them with the health, body, skills, and interests that will enable them to excel in a world that is rife with inequities. Within the contemporary sperm banking industry, individuals and families attempt to obtain these privileges through the power of purchase.

This dissertation is ultimately a study about the propagation of privilege and how the contemporary sperm banking industry is a site where individual consumers aspire to select the traits, features, and aptitudes of their future offspring—hoping their children will live advantaged and successful lives. These efforts are carried out through the power of purchase and they are supported by an increasingly biomedicalized reproductive marketplace wherein health is a commodity that individuals must pursue—typically by purchasing “techno-scientifically enhanced” products and services (Clarke, Shim, Mamo, Fosket, Fishman, 2003; Clarke, Mamo, Fosket, Fishman, and Shim 2010; Clarke and Shim 2011; Mamo 2010). Much like the couple meeting with the geneticist in the 1997 movie *Gattaca*, clients of donor sperm seek to use emerging reproductive technologies, supported by genetics “science,” to create the best possible child that they are capable of producing. Their hope is for a child that is the epitome of physical, mental, and genetic health—unburdened by physical and mental disorders and diseases, healthy and intelligent with an aptitude for success and achievement. Clients of donor sperm aspire to

create a child who possesses the social and phenotypical traits that will provide advantages and privileges, a child who will be *anything* but average.

2 WHITE LIKE ME: THE PROPAGATION OF PRIVILEGE AMONG WHITE WOMEN CLIENTS OF DONOR SPERM

In the spring of 2016, *The Washington Post* published an opinion piece by Aaron Halbert, a self-professed white Evangelical missionary who, along with his white wife, chose to expand their family using in vitro fertilization and the lesser-known practice of embryo adoption.¹ Having already adopted two black children, the couple agreed that selecting black embryos would enable all their children to feel connected to one another through their shared racial background (Halbert 2016). The procedure led the couple to birth triplets — adding three black daughters to their already transracial family. Responses to the story were quick and divisive. While some commended the Halberts on their dedication to what they viewed as God’s work, others were appalled by the situation — noting their fears for the children, whom they believed would grow up in a (white) home lacking in proper racial socialization (Augustin 2016; Rogers 2016).

Compare this story with the widely-publicized court case of a white lesbian couple who sued Midwest Sperm Bank for providing them with sperm from an incorrect donor — a donor who also happened to be black (O’Brien 2016; Spiegel 2014). While noting their absolute love and adoration for their biracial daughter, the suit cited the unexpected challenges and consequences of raising a child of color (O’Brien 2016; Spiegel 2014). In particular, the couple noted their cultural incompetence as white women attempting to raise their biracial daughter in a small, homogeneous, and racially intolerant town (O’Brien 2016; Spiegel 2014). One of the mothers, Jennifer Cramblett, further explained that she felt ill-suited to meet the needs of a child

¹ Embryo adoption is when an individual or couple purchases a fertilized embryo that was donated due to there being excess embryos created through the process of in vitro fertilization (Mellinger 2016).

of color since she and her family are all white: “I want her to feel very connected to all parts that make up who she is. I’m not able to give her that part of heritage, and neither is anyone from her family” (Belware 2014). Public opinion was similarly swift and contentious. Some agreed that the sperm bank should be held accountable for its error (Spiegel 2014); some expressed concern for the daughter who would grow up feeling as though her birth was a burden on her family (Belware 2014; Culhane 2014); others accused the couple of being racist (Culhane 2014); and several mocked the couple for crying foul at the mere prospect of encountering systemic racism — likely for the first time in their lives (Bindel 2014; Culhane 2014).

These examples, accompanied by their ensuing divisive responses, highlight how our culture continues to struggle with anxiety about the relationship between assisted reproductive technologies (ARTs), “racial purity,” and “legitimate” kinship structures (Quiroga 2007; Roberts 1997). Such stories also draw attention to the persistence of cultural assumptions regarding familial racial homogeneity, particularly in relation to the rearing of children of color, who face the increased burden of racial inequities. The belief that white parents may not be suited for raising children of color extends beyond the assisted reproductive market (Fox 2009). Indeed, “in the contexts of interracial custody and transracial adoption, judges and social groups have argued explicitly that racially homogenous families should be preferred because people are better equipped to parent children of the same race” (Fox 2009:1891).

Since the 1970s, the National Association of Black Social Workers (NABSW) has been one of the most vocal opponents against the adoption of black children by white adopters (Hollingsworth 1998, 2008; Jennings 2006; NABSW 1972). In addition to expressing concern for the abilities of white adopters to help black children develop a healthy racial identity and connection to the larger black community, the NABSW (1972) further argues that black children

must learn the survival skills necessary for living in a racist society. Through their lived experience with discrimination and oppression, black parents can offer a nuanced and balanced understanding of how to navigate one's day-to-day life as a racially marginalized person living in a white-dominated society (Abdullah 1996; Barn 2013; Jennings 2006; NABSW 1972). Researchers refer to these skills as cultural and racial competencies (Barn 2013). Cultural competency is the ability to transmit the necessary beliefs, values, and behaviors, to ensure children of color develop a healthy racial or ethnic identity (Barn 2013). Racial competency refers to one's ability to prepare children of color for a life that will be fraught with racial discrimination and oppression (Barn 2013). Opponents of transracial adoption argue that white parents lack these vital competencies and as such, they are ill-equipped to adequately raise children of color who must learn how to navigate living in a white dominant society (Abdullah 1996; Jennings 2006; NABSW 1972).

Proponents of transracial adoption claim that children of color, placed with white families, are psychologically well-adjusted and display healthy racial identities (Bartholet 1995; Hollinger 1998; Hollingsworth 1998, 2008; Jennings 2006). They argue against requiring race-matching, noting that such policies delay placement and exist as a form of "reverse discrimination" against white families (Bartholet 1995; Hollingsworth 1998; Jennings 2006). The purpose of this paper is not to argue for or against the creation of transracial families via donor insemination. Rather, in this study, I examine how the concerns of white women pursuing donor insemination are consistent with those concerns articulated by opponents of transracial adoption. Some white women identify themselves and their families as lacking in the cultural and racial competencies deemed necessary for raising a child of color. I also expand upon the existing research on the role of race in the donor selection processes of white women specifically. White women made up

the majority of interviewees in this study.² I highlight how some white women who have gone through the process of selecting a sperm donor from an online sperm bank recognize race as a system of oppression, wherein non-whiteness functions as a disadvantage that could potentially work against themselves, their children, and their families. These same women simultaneously uphold the invisibility of whiteness—ignoring how they personally benefit from white supremacy and its privileges. By choosing a white donor, they aim to protect their families against potential marginalization. In doing so, they maintain their own racial privileges and pass those on to their children.

2.1 What Makes a Family “Legitimate”? Biological Connectedness & Racial Homogeneity

Throughout U.S. history, race has played a central role in framing both “what” and “who” constitutes a legitimate family in our society (Baca Zinn 1993; Quiroga 2007; Roberts 1997). Practices within the assisted reproductive market reflect this history and the underlying belief systems that support the reproduction of the idealized family form — that of the two-headed, white, heterosexual, nuclear family (Mamo 2005, 2007; Quiroga 2007; Roberts 1997). These ideologies are rooted in racist, heteronormative assumptions about procreation and the subsequent biogenetic links between parent and child (Becker 2000; Marre and Bestard 2009; Nordqvist 2010, 2012; Quiroga 2007). Such thinking promotes the expectation that children are created through heterosexual intercourse and that the resulting child will be biologically connected to both parents. Assumptions of monoraciality, heteronormativity, and biological connectedness continue to influence mainstream understandings of kinship and family forms

² 30 of the 33 interviewees identified themselves as white.

(Goss 2018; Jones 2005; Marre and Bestard 2009; Mason 2008; Nordqvist 2010, 2012; Quiroga 2007; Walther 2014).

Due to the pervasive nature of these ideologies, donor selection largely revolves around “matching” the physical traits of the donor to those of the clients (Becker 2000; Mamo 2005, 2007; Nordqvist 2010, 2012; Pennings 2000; Quiroga 2007). While consumers internalize broader cultural values regarding kinship and biogenetics, the industry also pushes its clients to make selections that are consistent with the hetero-patriarchal familial archetype (Becker 2000; Kroløkke 2009; Quiroga 2007). Given such emphases, the first choice made by consumers tends to be race or ethnicity (Fox 2011; Moore 2007; Nordqvist 2010, 2012; Quiroga 2007; Walther 2014). When a child does not “match” their parent(s) racially, the family’s status is more likely to come under question (Becker 2000; Hertz 2006; Nordqvist 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016).

Families that deviate from the traditional model — such as single-parent, queer, and/or interracial or transracial families — face devaluation, stigma, and mistreatment (Bernstein and Reimann 2001; Bock 2000; Dalmage 2000; Hertz 2006; Nordqvist 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016). To avoid potential alienation and discrimination, clients utilizing donor insemination often attempt to assimilate into these hegemonic value systems by selecting donors who will produce children that share familial resemblance (Becker 2000; Nordqvist 2010, 2012; Ryan and Moras 2016). In creating racially homogeneous families that look as though they were produced through heterosexual sex, they attempt to minimize the amount of stigma and discrimination both they and their child may face (Becker 2000; Hertz 2006; Nordqvist 2010, 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016).

2.2 Lesbians & Single Women Gain Access

Until the 1990s, donor insemination was the most effective treatment available for male infertility (Almeling 2011; Barney 2005; Becker 2000; Walther 2014). The invention of intracytoplasmic sperm injection (ICSI), wherein the sperm is injected directly into the egg, enabled some men who were once considered infertile, to impregnate their wives; thus, reducing the need for donor sperm (Almeling 2011; Inhorn and Birenbaum-Carmeli 2008; Mamo 2005; Pennings 2000). With the creation of these technologies, physicians and reproductive specialists began to encourage heterosexual couples to utilize those ARTs that prioritize the hetero-patriarchal nuclear family model; one wherein each parent has a biological connection to the child and the father's paternity and virility is unchallenged (Becker 2000; Mamo 2007). The medical institution's support for ICSI, as well as the role of physicians in preventing access to knowledge about donor insemination (Becker 2000; Mamo 2007), led to a mass shift in the market. The loss of their heterosexual consumer base led commercial banks to reach out to populations it had once excluded: single women and lesbians (Almeling 2011; Barney 2005; Mamo 2007; Rodino et al. 2011).

Today's consumer base still predominantly consists of middle and upper-class white individuals and couples (Becker 2000; Quiroga 2007). However, lesbian couples and single women now constitute approximately two-thirds of the donor insemination market (Lewin 2016). Since sperm banks opened their doors to this once-deemed undesirable clientele, scholars have extolled the potential of donor insemination to upend traditional conceptions of family (Becker 2000; Dunne 2000; Kroløkke 2009; Mamo 2005, 2007; Nordqvist 2010, 2012; Quiroga 2007; Roberts 1997; Tober 2001). They argue that donor insemination has the ability to dismantle societal expectations of heterosexual parentage, biogenetic ties, sexual conception, and racial

homogeneity (Becker 2000; Dunne 2000; Jones 2005; Kroløkke 2009; Mamo 2005, 2007; Moore 2007; Nordqvist 2010, 2012; Roberts 1996; Tober 2001; Quiroga 2007). Quite the opposite has been true. Instead, studies show that families constructed through donor insemination tend to reify those very beliefs, rather than subvert them (Becker 2000; Jones 2005; Mamo 2005, 2007; Nordqvist 2010, 2012; Roberts 1997; Ryan and Moras 2016; Tober 2001; Quiroga 2007). Rather than create family forms that visibly challenge those long-held assumptions of parentage and kinship, queer women and single mothers by choice use donor insemination to produce families that go undetected as atypical (Hertz 2006; Jones 2005; Mamo 2005, 2007; Nordqvist 2010, 2012; Ryan and Moras 2016). This is predominantly done through the process of race and phenotype matching (Becker 2000; Hertz 2006; Jones 2005; Mamo 2005, 2007; Nordqvist 2010, 2012; Ryan and Moras 2016).

2.3 White Women Making Donor Selections

To date, most research critiquing the role of race within the donor insemination market centers on the experiences of white lesbians (Mamo 2005; Nordqvist 2010, 2012; Ryan and Moras 2016). White women—lesbians and single mothers by choice—make up a large proportion of the sperm banking industry’s client base (Hertz 2006; Lewin 2016; Mamo 2005; Nordqvist 2010, 2012; Quiroga 2007). Given cultural expectations on biogenetics and race-matching within the legitimization of “ideal family forms,” selecting donors within one’s race is common practice among *all* groups—not just white people or lesbians (Marre and Bestard 2009; Fox 2011; Moore 2007; Nordqvist 2010, 2012; Quiroga 2007; Walther 2014). As such, there is an overwhelming consensus among researchers that race plays a vital role in the process of sperm donor selection in general (Fox 2009; Mamo 2005; Nordqvist 2010, 2012; Quiroga 2007; Ryan and Moras 2016).

The existing research that explores the role of race within white women's sperm donor selections argues that white women aren't thinking about race at all — at least not overtly, and certainly not in a critical manner (Mamo 2005; Nordqvist 2012; Ryan and Moras 2016). Scholars have noted how the role of race primarily goes unexamined by white women; race-matching is both taken-for-granted and assumed (Mamo 2005; Nordqvist 2012; Ryan and Moras 2016). For white women going through the donor selection process, choosing a white donor requires no explanation or afterthought (Mamo 2005; Nordqvist 2010, 2012; Ryan and Moras 2016). Indeed, interviews with white lesbians about their donor selections generally avoid talking explicitly about race (Mamo 2005; Nordqvist 2012; Ryan and Moras 2016). Instead, they speak in ways that point to, but never overtly identify race as relevant — rather, they use indicators such as hair or eye color, or ethnicity as influencing their donor selections (Ryan and Moras 2016). These features are highlighted as vital to producing familial resemblance (Jones 2005; Nordqvist 2010, 2012; Ryan and Moras 2016). In ignoring the significance of race explicitly, they retain the invisibility of whiteness and reproduce the heteropatriarchal white power structure (Quiroga 2007; Nordqvist 2012; Ryan and Moras 2016).

White single mothers by choice also prioritize race-matching in their sperm donor selections (Hertz 2006). As Hertz (2006:55) notes, single mothers by choice are not “out to change the world” in terms of creating alternative family models. Although they may build their families using non-traditional methods such as donor insemination, they work hard to ensure that their children will fit into their extended families and communities (Hertz 2006). That is, they avoid drawing attention to themselves and their families by reifying the dominant kinship model through the construction of a racially homogenous family that looks as though it was created through heterosexual intercourse. Single mothers know that they face increased scrutiny and

devaluation compared to their married and coupled counterparts (Bock 2000; Hertz 2006; Hertz and Ferguson 1997). By having children who resemble themselves, they can blend in and protect themselves against potential marginalization.

Similarly, white lesbians view themselves as already marginalized by their sexuality. Confronted with the possibility of having a child of color, white lesbians justify their selection of white donors by pointing out how having a transracial family would bring on further stigma and discrimination (Nordqvist 2012). White lesbians further argue that by selecting a donor of color, they would place an unnecessary and increased burden on their children (Nordqvist 2012). Ultimately, when white people create families that are racially homogenous, they can maintain legitimacy and privilege in a society that devalues families that break away from the idealized white, heterosexual, nuclear family model (Hertz 2006; Nordqvist 2010, 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016).

2.4 Data Collection

This study is a part of a larger project which sought to identify how various forms of inequality such as racism, classism, ableism, heterosexism, and homophobia are reproduced within the donor insemination market. Examining both the marketing and the consumption of donor sperm, the project included 33 client interviews and 32 questionnaires,³ as well as a content analysis of marketing materials and over 100 sperm donor profiles from four major online sperm banks. The data under consideration here consist solely of the content collected through 17 interviews with (mostly) white women who spoke at length about the role of race in

³ The researcher asked interviewees to complete an anonymous questionnaire on their sperm donor selection preferences. Participation was voluntary and of the 33 interviewees, one chose not to submit a questionnaire.

their donor selection process. More specifically, this paper examines the responses of these interviewees to the question, “*What role did race play in your donor selection?*”

The majority of respondents initially responded in ways that are consistent with the existing literature — highlighting white women’s taken-for-granted assumptions about race-matching (Mamo 2005; Nordqvist 2010, 2012; Ryan and Moras 2016). However, interviewees were asked to clarify their responses, which led to more critical reflections on race as a potential source of disadvantage and discrimination. The analysis here centers on those respondents who explicitly addressed race *and* went beyond typical taken-for-granted “race-matching” narratives. Of the 33 women who were interviewed for this project, 17 fell into this category; all of them selected a white donor.⁴ Sixteen identified as white and one identified as Asian.⁵ By focusing on this sub-group of the larger study’s sample, I offer an extension to the existing literature on white women’s experiences with sperm donor selection.

To be included in the study, interviewees must have gone through the process of selecting a sperm donor from an online sperm bank. Recruitment consisted of convenience sampling via personal and professional networks, as well as outreach to fertility clinics, online forums, blogs, and Facebook communities targeting those seeking pregnancy through donor sperm. Although inclusion was not limited to female-bodied or women-identified individuals, interviewees primarily⁶ fell into two main categories: (1) Lesbians and queer women in relationships with cis women or trans men; and (2) single mothers by choice who primarily identified as heterosexual.

⁴ Of the 33 respondents, 27 chose a white donor and the remaining six chose a donor of color for the purpose of “matching” their partners who were women of color.

⁵ A total of 33 women were interviewed for this project; three identified as non-white.

⁶ One respondent had previously been married to a man, although she did not explicitly identify herself as heterosexual. This respondent could neither be categorized as a coupled lesbian/queer woman or as a single mother by choice.

Respondents were overwhelmingly liberal, college educated, and professional women with household incomes placing them in the middle- to upper-middle-class range.

Between the fall of 2015 and spring of 2016, I conducted in-depth telephone interviews with 33 women residing in the United States who had gone through the process of selecting a sperm donor from an online sperm bank. Applying a modified version of Glaser and Strauss' (1967) framework for open, axial, and selective coding, I repeatedly analyzed transcripts from each interview to identify emergent themes and concepts related to respondents' underlying beliefs about race and its connection to the donor selection process. These concepts informed not only the development of theoretical insights, but also the continued collection and analyses of data (Charmaz 2014; Glaser and Strauss 1967). Through this constant comparative method (Charmaz 2014), I identified several key concepts that helped develop a more nuanced understanding of how white women conceptualize race, and how those beliefs shaped their donor selections.

Respondents' view of non-whiteness as a potential burden is evident in: their perceived lack of preparedness to raise children of color in a white supremacist society; a recognition that their lives would be "easier" or "simpler" if they chose a white donor; and the view that non-whiteness would further stigmatize their already marginalized families. By selecting white donors, they are able to avoid those potential disadvantages and opt out of racist experiences altogether. While these respondents are conscious of race as a system of oppression, they primarily focus on *non-whiteness* as a disadvantaged position. The majority avoid identifying whiteness as an advantaged or privileged position — although, several framed their selection of white donors as making their lives easier or simpler. By framing race in terms of non-whiteness

and disadvantage, white interviewees help to support and perpetuate both the invisibility and power of whiteness (Crenshaw 1991; Ryan and Moras 2016).

2.5 White Women Not Equipped

Opponents of transracial adoption critique the abilities of white people to properly raise children of color (Abdullah 1996; Jennings 2006; NABSW 1972). They argue that white people lack the cultural and racial competencies necessary to aid children of color in developing the identity and resources they will need to successfully live as racial minorities in a white-dominated society (Barn 2013; NABSW 1972). Similar concerns are expressed by white women interviewees who openly addressed how race shaped their sperm donor selections. One of their primary concerns centered around their perceived inability to educate and connect with children of color on the basis of a shared heritage or life experience. During their interviews, donor race became a point of reflection wherein white women clients of donor sperm identified their perceived cultural incompetencies.

When asked about the role of race in their donor selection process, most responses revolved around physical matching narratives. When encouraged to elaborate, some explained that, as white women, they lacked the ability to appropriately rear children of color, as evidenced in Jessica's comments:

We were very upfront about that. I mean we – my partner is white and I'm white – and we wanted our kid to look like us, and you know, maybe that's not a very PC [politically correct] thing to say, but that's how we felt.

Interviewer: Is it primarily just for appearances, then, in terms of having a family that looks like one another?

Jessica: It's not so much that we look physically like each other, but I think that we don't – we're not particularly well-equipped to raise a child of another race, and we just wanted to make sure that, you know, that we felt comfortable and capable of doing that, and I think there's just not – we wanted to raise a kid that we could – that's our experience and our heritage and so, you know? I didn't want

to feel like I was gypping [sic] my kid out of their heritage. If the donor had been, you know, Asian, we couldn't teach them anything about Asian culture. I think that would have been hard.

Jessica claims that she and her Jewish wife lack the ability to offer the cultural socialization and knowledge required for a non-white child. While she veers between her general level of discomfort and her perceived lack of cultural competency altogether (e.g., “we couldn’t teach them anything”), her commentary denotes a clear understanding that a child of color has specific needs with respect to their culture and heritage. Without a shared racial background, she views herself and her partner as ill-equipped to provide a hypothetical child with what she views as the cultural upbringing required. Nicole, a white single mother by choice, also articulates these concerns:

You know, there are cultural issues involved with different races, and I don't know that I could do justice to that.

Interviewer: Could you elaborate on what you mean by that?

Nicole: Well, I mean, you know, there are – whether they're African-American or Asian or whatever, it's not just, you know, the physical characteristics. There's a cultural piece to race, and if I had a child that was mixed race, I would feel that it would be something important to them to understand that cultural piece, and I don't know that I could do justice to making them understand it, or helping them understand it.

Interviewer: So, as a white woman, not necessarily being able to teach them in the ways of a different sort of racial experience?

Nicole: Yeah.

Advocates of transracial adoption contend that white parents are fully capable of providing children of color with the support and resources necessary for a healthy identity and cultural development (Bartholet 1995; Hollingsworth 1998, 2008; Jennings 2006). The concerns of white women clients of donor sperm are far more consistent with those of the critics of transracial

adoption. These progressive-identifying women⁷ believe that there are specific needs that children of color have when it comes to developing a healthy racial identity and sense of one's heritage. As white women, they fear that they are incapable of transmitting the beliefs, values, and behaviors necessary to be culturally competent parents of children of color.

The concern surrounding cultural competence was exclusively expressed in regards to non-whiteness. Interviewees spoke freely about selecting white donors of differing and varying ethnic identities; they never once raised concerns about not being equipped to teach white children about differing ethnic cultural values or beliefs. Lacking a shared (white) ethnic identity was not a concern for these women — to be white was enough. White women clients of donor sperm don't worry about appropriately rearing a white child in their donor's Irish, or Norwegian, or Croatian culture and heritage. Rather, these women only articulated fears of cultural incompetence with respect to rearing hypothetical non-white children. On the other hand, they would share their whiteness and identity with any hypothetical white child — regardless of ethnic origin.

Considerations of cultural competency are unnecessary in such cases, as is articulated by Angela. When discussing the potential marginalization one might face for having a mixed-race family (a point I explore next), she notes, "Being in a transracial family and having to explain that, or having to figure out ways of honoring their ethnic heritage, when if they were white, (pause) we could just ignore that, you know?" Racial homogeneity allows white parents to sidestep the issue of cultural competency altogether. Being white, they understand what it is like to live in this world as a white person. From a cultural competency perspective, they possess the

⁷ All 33 respondents identified themselves as either progressive, liberal, left-leaning, Independent, or Democrat.

lived experience and identities necessary to transmit that knowledge to their white children, if necessary. The need for racial competency within white families is a non-issue. While children of color need to develop skills that will assist them as they move through their lives as racial minorities in a white-dominated society (Abdullah 1996; Barn 2013; Jennings 2006; NABSW 1972), such skills are unnecessary for white children. In a culture that frames race as non-whiteness (Dyer 1997) and non-whiteness as inferior, white people experience the world as though they are 'unraced' (Crenshaw 1991).

This is one of the primary reasons that critics of transracial adoption are adamant that white adopters are ill-equipped to raise children of color. White people lack the first-hand lived experiences that people of color face as they navigate marginalized and discriminated positions in a world structured by systemic racism. Critics of transracial adoption argue that it is the day-to-day, lived experiences that generate racial competencies for people of color (Abdullah 1996; Barn 2013; Jennings 2006; NABSW 1972). As members of the idealized racial group, white people can move freely and without regard for race or racial oppression (McIntosh 1989). This is just one of the many privileges that white persons are afforded in a white supremacist society.

Although these white parents may never personally experience what it means to be a person of color in a white supremacist society, they do experience and overcome racialized discriminations targeting their children and transracial families (Barn 2013; Goss 2018; Leslie, Smith, and Hrapczynski 2013). Transracial families find ways to cope with and manage the multitude of oppression, discrimination, and mistreatment inflicted by a white supremacist society (Barn 2013; Goar 2014; Goss 2018; Leslie et al. 2013). For instance, white parents attempt to foster the development of healthy non-white identities in their children by connecting them to communities of color and social organizations (Barn 2013; Goar 2014; Goss 2018).

Furthermore, research on transracial adoptive families finds that although adopted children of color report experiencing significant racial discrimination, the racial socialization provided by their white adoptive parents seems to moderate the stress associated with that discrimination (Leslie et al. 2013). Ultimately, white parents in transracial families find ways to help their children navigate and cope with racialized oppressions—albeit from the perspective of someone who lacks the personalized and embodied experiences shared by people of color.

2.6 Racism and White Incompetence

When confronted with the possibility of having a child of color, white women clients of donor sperm acknowledge that we live in a racist society. They also highlighted their perceived ineptitudes in terms of racial competency. Interviewees spoke of the potential racism that children of color would face and how they, as white women, were uncertain of how they would (or if they could) help a child of color prepare for such a life.

Carrie: I don't know that I or (my partner) felt like we would be adequately prepared or necessarily appropriate to raise a child of color. If we wound up adopting one, that'd be a different story, because we'd probably wind up adopting through the foster system, so it's much more of a needs-based thing. But I don't think either of us felt like we could in, clear conscience, bring a child who was going to sort of face a lot of issues or oppression and potential marginalization knowingly into the world, knowing that we were not necessarily prepared to help that child navigate those issues because we just haven't gone through them.

Carrie, a white coupled lesbian, understands that our society is structured by systemic racism, and explicitly acknowledged that any child of color would be treated unfairly solely because of their race. As white women, neither she nor her partner has developed the knowledge or skill set that “prepares” one for dealing with racism and discrimination — let alone the ability to impart that knowledge on a child. Kelly, another white coupled lesbian, echoed these concerns:

People have so much anxiety about raising a child of color and being totally unprepared for that and like, what that means and how do you do that well, and like, there's just a lot. I mean I have friends who are partnered with black men who still, as like white moms, are just like, "God!" you know? And it's sad that we live some place that I would even think that, but we do, and so – how do you best prepare your children?

The fact that white women repeatedly identified themselves as ill-equipped or unprepared is telling. More specifically, this pattern is indicative of just how privileged they have been.

While they may have faced discrimination for being women, single mothers, or sexual minorities, they have and continue to benefit from white privilege in a white supremacist society. In choosing white donors, they are able to maintain their racially privileged positions. Neither they, nor their white children will face oppression on the basis of their race. When discussing her preference to have a white child, Pamela explains, “It really just comes back to my own comfort, and honestly, my fears for the child.” She elaborates:

I already feel so overprotective of my friends that have the little boy that's the same age as my daughter. I'm like, "Oh my God! How are we going to protect him?" Because he's African-American, and I just am like, "The world is just going to be out to get him," and I can't even handle that. I love him. I cannot have that happen.

Many interviewees framed their concerns as centering the needs and protection of a hypothetical child of color; however, they also acknowledge their own discomforts. In doing so, they make apparent their unwillingness to open themselves, their families, or their children to the prospect of experiencing racism. Chelsea explicitly makes this connection as she denotes the appeal of choosing a white donor: “At least in the U.S., being white is a privilege, so I don’t know why I wouldn’t give that to my child if I could, you know?”

While the passing on of racial privilege is not always so explicitly articulated, some respondents expressed an understanding of race and racism as hierarchical. When expressing her

surprise that three of the black lesbian couples that she knew had each chosen white donors, Amanda, a white woman coupled with a white trans man, speculates: “I don’t know if they possibly did it to give their kid the best chance. I mean, just because, you know, of how society is? And maybe they thought they would give their kid an advantage as far as how they would be treated in school, or wherever?”

Interviewees consistently spoke about the struggles white families would have in rearing children of color and how having a biracial child (as white women) would serve to complicate the life of the child and their family. Alternatively, Amanda proposed that in the case of women of color, choosing a white donor could instead offer an advantage. From this perspective, she proposes that having a biracial child is more advantageous than having a child who has two black parents. Hunter (2002, 2007) notes that light-skinned people of color receive more social capital and privileges than do dark-skinned persons of color. This differentiation privileges light-skinned people of color in key areas of life such as in education, income, housing, and marriage (Hunter 2002, 2007). Colorism, the preference and privileging of lighter skin tones within communities of color, is a well-documented form of internalized discrimination (Hunter 2002, 2007).

The belief that choosing a black donor would be disadvantageous, even among women of color or by white women in interracial relationships, was also present. In discussing her selection of a white donor, Michelle, an Asian single mother by choice who selected a white donor, explained her hesitation to use a black donor:

Let's see. I really wanted to have, like – since I'm Asian– my baby would be mixed race. But I did not want an African-American donor just because I know my child would face more social stigma, and without a partner of that race, I think I would have felt like I wasn't really equipped to deal with it. I didn't want to bring that on myself, honestly.

Michelle's fears of colorism for her hypothetical child are not unfounded. There are distinct differences in how racism functions against varying communities of color (Chou 2015; Collins 2005). Social, cultural, and historical values assigned to the black community are different than those assigned to the Asian community (Chou 2015; Collins 2005). These differing beliefs and values result in differential treatment and outcomes. People of color from all racial backgrounds struggle with higher rates of inequality than do white people on a variety of important social measures such as poverty, income, wealth, education, and employment (Mather and Jarosz 2014; Parker, Horowitz, Mahl 2016). Furthermore, black Americans typically experience higher rates of inequality than do Asian and Latino Americans on such measures (Mather and Jarosz 2014; Parker et al. 2016).

What's intriguing about both Amanda's and Michelle's comments is that they contradict dominant values regarding familial resemblance and racial homogeneity. Rather than idealizing a family form in which everyone looks the same—via skin tone and racial phenotype—they instead prioritize the selection of whiteness. Whereas blackness is identified as a race to avoid, whiteness maintains its appeal, regardless of the race of the client. Erica offers further insight into how black donors can be devalued. Erica is a white woman who chose a black donor to ensure the child would resemble her black lesbian partner. She describes some of the racist comments she has heard from individuals who questioned her donor choice (and resultant biracial child): "I have gotten the question, like, 'Why would you choose a black donor?' As though, like if I can have anything, *why would I choose something that's not ideal?* Which I thought was a really fascinating question."

Erica's choice of a black donor is consistent with dominant kinship ideologies regarding biogenetics and hetero-patriarchal family models — it is choice that is both expected and

assumed. Donor insemination offers a unique form of family planning wherein clients can (presumably) select and prioritize the traits they would like to see in their children. The questioning of Erica's choice boils down to others' racist devaluations of blackness in a white supremacist society. Within this context, whiteness prevails as one of the most visible and powerful forms of privilege that a parent can pass on to their child.

2.7 A Simple Kind of Life

Making donor choices on the basis of selecting "privileged" or "advantageous" qualities was consistent throughout interviews. This was true for characteristics or traits beyond race such as donor height, athleticism, intellect, achievement, and success (areas of analysis that are explored elsewhere by the researcher). Choosing a donor of color would require white women to confront systemic racism from a marginalized position — either via their child of color or as a member of a transracial family. Not only do these women feel unprepared to raise a child of color, they also recognize that having a racially homogenous family would simply make things "easier" or "simpler" for themselves, their family, and their children.

Interviewer: Can you tell me about the role race played in your experience with donor selection, why you chose the race that you did?

Chelsea: Well, I think it's just easier. It's easier to explain or to not even — the question never comes up. If your child looks like you, the question never comes up, like, "How did this happen? Oh, you had a donor? Oh, you weren't married? I think it's just easier if your child looks like you.

Rachel, another white single mother by choice, raises this point:

I wanted the child to look as much like me as possible. So, when anyone said, "He looks like you," or, "She looks like you," I could say, "Yes." And there'd just be no question. I just imagine if, you know, I picked a Hispanic or an Asian donor and people would be like, "Oh, so, your donor was...?" For me it just kind of prevented the questions of, "Your donor is Hispanic or Asian," you know...questions I didn't want to answer.

Interviewer: So, if the child was, say, biracial for instance, people might question the whole situation more?

Rachel: No, it's not even that they'd question the situation but it's *explaining the process of why* I selected an Asian donor or a Hispanic donor or an African-American donor, you know? More, "*Why did you do that?*" I think I'd be fine with the child, but it was just more explaining my choice. I just wanted that off the table.

When clients of donor sperm choose to create families that share physical characteristics such as skin color, they conform to the hegemonic narrative of what a family should look like. As a single white woman, having a child of a color would increase her chances of being seen as a non-conformist in terms of family structure. Single mothers already face stigma and discrimination in our society (Bock 2000; Hertz 2006; Hertz and Ferguson 1997). Interracial couples also face stigma and marginalization (Dalmage 2000; Nordqvist 2012; Quiroga 2007; Roberts 1997); this can be particularly harsh for white women who have historically been pressured to uphold 'white racial purity' within a white supremacist society (Roberts 1997). To be recognized as a single woman who chose to have a child outside of a relationship via ARTs, Chelsea could face additional stigma and discrimination. In choosing a white donor, she maintains a level of invisibility and protection in this regard. Furthermore, to choose to have a child of color as a white woman without a partner of that race, her motives could possibly be questioned.

Pamela, a coupled white lesbian, also notes how it "would have been kind of an unusual choice in a couple where we're both white to choose a nonwhite donor. My guess is that people typically pick a race-matching donor, but I might be wrong." These women are well aware of societal expectations to produce families that look alike. They're also aware of the discrimination faced by families who do not conform to such a model. By blending in and creating racially homogenous families that look as though they were produced via heterosexual intercourse, clients of donor sperm protect themselves and their families (Hertz 2006; Nordqvist

2010, 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016). For white women who view themselves as already marginalized, adding in the complexity of race (read: non-whiteness) would serve to only further marginalize their child (Hertz 2006; Nordqvist 2010, 2012; Mamo 2005).

2.8 Racial Homogeneity and the Avoidance of Double-Stigma

Nordqvist (2012) notes how white lesbians using donor conception fear that their child will be stigmatized because of their non-traditional family form. Choosing a donor of color would put their child at risk for both racism *and* homophobia (Nordqvist 2012). White lesbian interviewees responded similarly.

Brenda: It was just so important for me to feel like the baby, like if I or my partner was going to be with the baby in public, that it really resembled us. I just feel like the child's going to be raised with already some challenges of having two moms, and to me it was just, to simplify it to make it easier for the child, just by picking white over black. It was just more, "Okay, yes, this could easily be your Mom." Even though there's many interracial marriages and things like that, but just to kind of simplify it and give one less challenge.

Single mother's by choice also highlighted this concern, as described by Maureen:

I thought, "I am bringing a child into the world who's going to be, quite possibly, raised by a single parent," which I don't know if there will ever be any complications or anything, you know, if they'll have feelings about that. I don't know what their feelings will be about being raised by a single parent. But it was one of my concerns and, you know, something I've thought about since I was trying to conceive is any disadvantage my child might have, from being from a single-parent family and what those factors might be. What can I do to mitigate that? What can I do to – you know, it's like I put a lot of thought into that. And I thought that, if they were biracial, that that might add just a more complicating factor because I've read quite a bit about kids who are biracial. By and large, I'm sure there are no problems with being biracial, but you know, I don't want my child to have more than one identity crisis, you know, being from a single-parent family, being from an anonymous donor, and then being biracial, too, so that was pretty much my thought process.

These women want to protect their children and their families from any potential discrimination or mistreatment. While they may be disadvantaged because of their family type — either single mother or lesbian-headed — these families will avoid racial discrimination. As white women, they are able to maintain their own racial privilege and pass it on to their children. In this regard, white women clients of donor sperm are able to opt out of racist experiences altogether; this is a privilege that is not afforded to women of color using donor insemination. Whereas white women are the only ones capable of producing white children in a white supremacist society, women of color will always birth children of color (Roberts 1997). Regardless of one's intent or level of racial consciousness, any reproduction of whiteness is a reproduction of inequality in a society wherein whiteness exists as the dominant and privileged racial category.

2.9 Discussion

Although physical resemblance may be what guides white women in selecting white donors, Fox (2009:1886) speculates that, “it is not unreasonable to think that at least for some parents, the social norms that systematically favor whites over blacks inform the norms that give rise to racial preferences in assisted reproduction.” However, the prevailing argument in the extant research on white women's donor selections is that white women are not contemplating the role of race at all (Mamo 2005; Nordqvist 2012; Ryan and Moras 2016). Indeed, race remains unexamined and taken-for-granted, despite it being one of the first choices that a client makes (Fox 2011; Moore 2007; Nordqvist 2010, 2012; Quiroga 2007; Walther 2014). Such findings are a reflection of the inherent privilege of white supremacy itself (Crenshaw 1991; Ryan and Moras 2016), as the invisibility of whiteness helps to maintain the unequal powers, privileges, and oppressions within a white supremacist society (Crenshaw 1991; Ryan and Moras 2016).

This study documents the persistence of white invisibility and its associated privileges as it occurs among white women clients of donor sperm. Even within the context of explicit conversations about whiteness, racism, and oppression, white women fail to acknowledge how they specifically benefit from whiteness and white supremacy. However, these women display complex, critical, and conscious understandings of race; they recognize that race is a system of oppression and privileges wherein non-whiteness functions as a potential disadvantage. They are also aware that children of color and transracial families have struggles that are not imposed upon white people or racially homogenous families. Rather than face the potential stigma, discrimination, or mistreatment that is associated with racism, they can maintain their racial privilege and pass it on to their children. In choosing a white donor, they conform to the dominant narrative of what constitutes a family: a racially homogenous family unit, seemingly connected by biology via heterosexual sex (Hertz 2006; Nordqvist 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016).

As white women describe their hesitation to use a donor of color, they shine a light on their own racial privileges — although, not always consciously. While respondents spoke about the potential harm that systemic racism can cause for communities of color, they were less likely to identify how they directly benefit from *and reproduce* white supremacy. In acknowledging their own ineptitudes in terms of cultural and racial competencies, they make apparent how they have lived without personal exposure to racism. As white women in a white supremacist society, they do not have to develop special skills or strategies to navigate racism from a marginalized position. Additionally, when white women talk about how their lives will be easier or simpler if they have a white child, they highlight the inequities and mistreatment placed upon transracial families and non-white communities. They are privileged in that they do not have to experience

such discrimination or mistreatment. Finally, as white women making donor selections, they can opt out of racist experiences altogether — for themselves, their families, and their children. Such opportunities are not available to people of color within the donor market.

The purpose of this paper is not to critique white women for making sperm donor selections that are quite frankly, rather ordinary; such choices are both expected and encouraged in our society. The fears and concerns articulated by white women clients of donor sperm are reactive to the ubiquitous and powerful ideologies that uphold oppressive systems of inequality. Hegemonic kinship ideologies offer legitimacy to a very narrow definition of family that is driven by hetero-patriarchal and white supremacist standards. Rather than face the retaliation commonly aimed towards those families and children who do not fit those standards, white women make donor selections that will benefit themselves and their children. As prospective mothers, these women want what is best for their children. Given the unique options that are available via the sperm donor market, they select characteristics and traits that will benefit their child in a society that is built upon complex intersecting systems of oppression. Their stories can help us to identify and document some of the ways that white families benefit from racism and white supremacy within the sperm donor market, and more broadly. Such documentation can further consciousness among allies and promote awareness among those who lack an understanding of how white supremacy functions in our day-to-day lives.

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3 RISKY BUSINESS: MARKETING RISK AND THE EXPANSION OF GENETIC SCREENING IN THE U.S. SPERM BANKING INDUSTRY

In the fall of 2017, a CBS News segment opened with the proclamation, “Iceland is on the verge of eliminating Down syndrome” (Quinones and Lajka 2017). Upon further viewing, the audience learns not of a treatment or cure for Down syndrome; rather, they learn that the Icelandic medical system has become incredibly proficient at preventing the births of children who may be born with Down syndrome (Quinones and Lajka 2017). In the early 2000s, the country’s medical system began implementing a combination of prenatal testing and genetic counseling to identify “at-risk” pregnancies. All pregnant women in the country are informed about the availability of this prenatal screening. This “combination test” includes an ultrasound, blood test, and genetic screening for chromosomal abnormalities—the most common of which is Down syndrome (Quinones and Lajka 2017). Although not mandatory, the majority of Icelandic women (80-85%) request the testing (Quinones and Lajka 2017; Will 2018). Of those who receive a positive result—100% choose to terminate their pregnancy. Similar termination rates exist in nearby countries: 98% in Denmark, 90% in the United Kingdom, and 77% in France (Quinones and Lajka 2017). In places like the United States, where religious ideologies and anti-abortion movements have stronger representation and influence (Hoare 2012; Pew 2018), the termination rate associated with combination testing is approximately 67% (Natoli, Ackerman, McDermott, and Edwards 2012; Quinones and Lajka 2017).

Pregnancy and childbirth have long fallen under the ever-expanding purview of medicalization wherein the natural process of human reproduction is framed as both pathological and risky (Chadwick and Foster 2014; Helén 2004; Lennon 2016; Lupton 1999; Rothman 2014; Simonds, Rothman, and Norman 2013). Indeed, pregnancy and childbirth are almost exclusively

framed in terms of the seemingly infinite risks posed to mother and child (Lupton 1999; Possamai-Inessedy 2006; Rothman 2014; Simonds, Rothman, and Norman 2013). Further, as the reach of reproductive technologies and medicine expands, so too does the ability to identify and manage new risks (Chadwick and Foster 2014; Helén 2004). Within a biomedical model of reproduction such as this (Chadwick and Foster 2014; Lupton 1999; MacKenzie Bryers and van Teijlingen 2010), pregnancy and childbirth are under constant surveillance—enabling experts to identify, manage, and minimize prospective risks (Chadwick and Foster 2014; Helén 2004; Lupton 1999; Lennon 2016). The effective surveillance and management of these risks relies on the widespread acceptance, legitimization, and internalization of expert knowledges coming from reproductive healthcare, biomedicine, genetics, and more recently, the techno-sciences and pharmaceutical industries (Clarke et al. 2003, 2010; Clarke and Shim 2011; Chadwick and Foster 2014; Conrad 2005; Lupton 1999; Mamo 2007, 2010).

Women—both pregnant and aspiring to be pregnant—often internalize the implicit and explicit messages embedded within these risk discourses (Lennon 2016; Possamai-Inessedy 2006). In doing so, they turn a critical gaze onto themselves, making personal choices that they believe will minimize the risks they will face in their pregnancy or for their potential child (Lupton 1999; Possamai-Inessedy 2006). Failing to take measures to reduce those risks can bring both stigma and blame on the prospective mother who finds that her body is “constructed as doubly at-risk”; she is responsible for her own health and that of her child (Lupton 1999:63). Ultimately, this obligation of maternal responsibility increases alongside the ability of emerging technologies and medicines to identify, detect, and treat any new or once unknown threats. As women learn of an increasing universe of potential threats to themselves and their imagined

children, they are expected to make choices that will ensure the health of those future children (Possamai-Innesedy 2006).

This study examines how genetic screening and genetic counseling are increasingly applied and promoted within the U.S. sperm banking industry. Although the sperm banking industry has always implemented a discourse of risk (Moore 2007; Schmidt and Moore 1998), it predominantly focused on the product at-hand: commercialized, medically-tested semen. In employing qualitative content analysis of four major online sperm bank's websites, I examine how the sperm banking industry has moved beyond merely depicting natural semen as inherently dangerous, enabling banks to effectively offer donor sperm as a solution to that risk. While sperm banks continue to place an emphasis on sperm itself as risky, clients of donor sperm—predominantly single women and lesbian couples—now encounter marketing materials that frame these aspirational mothers-to-be as potentially “at-risk.” The client herself is recognized as posing a significant threat to her future pregnancy and offspring, simply by being who she is at the genetic level.

Within a highly competitive industry wherein individual sperm banks must distinguish themselves from one another—often through the capitalization of emerging knowledges and technological innovations—sperm banks are centering their discourses of risk and pathology onto the clients themselves. In doing so, they cultivate new risks which can conveniently be identified and managed through the application of new services offered by their organization: genetic counseling and client genetic screening. As technologies and services such as these are increasingly applied and normalized, clients of donor sperm can engage in a new form of reproductive preventative care that takes risk surveillance and management into the realm of preconception. No longer must mothers wait for prenatal tests or screening that may diagnose her

child with a potential threat to their health such as Down syndrome or cystic fibrosis. Within the donor insemination market, health is a commodity (Mamo 2010; Maturo 2012). As such, clients of donor sperm are given the option to choose not just a sperm donor; they are also presented with the potential opportunity to purchase and select the health, abilities, and aptitudes of a child not yet conceived.

3.1 The History and Evolution of the Sperm Banking Industry

The emergence of the commercial sperm banking industry coincided with widespread fears of infection, disease, and illness (Almeling 2011; Barney 2005; Mamo 2007; Schmidt and Moore 1998). First established as a medical treatment for male infertility (Almeling 2011; Barney 2005; Becker 2000; Walther 2014), donor insemination was initially offered to middle and upper-class, white, married, heterosexual couples (Barney 2005; Mamo 2007; Schmidt and Moore 1998)—an exclusionary practice that continued well into the 1980s and 1990s when technological advances such as in vitro fertilization shifted the consumer base for donor insemination (Almeling 2011; Barney 2005; Mamo 2007). Today's consumers continue to be predominantly white and middle and upper-class (Becker 2000); however, lesbians and single women have become primary targets of the industry (Barney 2005; Rodino et al. 2011). While changing cultural mores regarding sexuality and what constitutes a family have played a role in altering who has access to these reproductive technologies, much of the change can be explained by the profit-driven motivations of the sperm banking industry, which grew out of smaller, physician-run medical clinics.

The transition from university-sponsored clinics towards large-scale corporate entities can best be explained by the advent of the HIV/AIDS crisis of the 1980s (Almeling 2011; Barney 2005) as well as technological advances in reproductive medicine (Almeling 2011; Mamo 2007).

Prior to the 1980s, the majority of providers were small, physician-run clinics that offered a modest selection of fresh sperm to heterosexual couples who were having trouble conceiving. At the time, fresh sperm was considered ideal in the insemination process. With the onset of the HIV epidemic in the 1980s, fresh untested semen was viewed as a public health threat due to its potential to infect recipients. Therefore, regulatory agencies recommended that donor sperm be frozen and quarantined for several months to ensure that its donor was free from HIV and other diseases (Almeling 2011; Barney 2005). Fearing infection, consumers began turning to cryobanks (Barney 2005; Plotz 2001). The once popular and preferred university-based clinics lacked the infrastructure to carry out cryopreservation and long-term storage; hence, commercial cryobanks took over the industry as a whole (Almeling 2011; Barney 2005; Mamo 2007; Schmidt and Moore 1998).

3.2 Technosemen

The ability to freeze and store donor sperm for months at a time ensured that it was safe and free from communicable diseases. It is out of this need to reduce risk and prevent the spread of disease that commercial sperm banks still base much of their marketing (Moore 2007; Schmidt and Moore 1998). In utilizing a discourse of risk, they frame the reproductive process—and natural sperm in particular—as inherently dangerous in its potential to infect as well as its potential to produce defective offspring (Mamo 2005, 2007, 2010; Schmidt and Moore 1998). The commercial sperm banking industry offers a solution to these risks in what Schmidt and Moore (1998) refer to as technosemen.

Technosemen is donor sperm that has undergone various medical, scientific, and technological tests and procedures. Not only is donor sperm checked for various sexually transmitted diseases, it is also tested for its quality and ability to help achieve fertilization. New

technologies enable donor sperm to be screened and manipulated, ensuring consumers that their purchased product will have the necessary sperm count, motility, and morphology to “get the job done” and (hopefully) achieve pregnancy. Sperm is washed and separated from its seminal fluid; it is examined for antibodies reducing chances of allergic reactions; it is tested for its ability to swim as well as its potential to penetrate an egg; it can have caffeine added to it to increase its motility; and it can even be manipulated to improve the chances of producing either a male or female child.

Since 2001, all sperm banks have been required by the Food and Drug Association (FDA 2018) to thoroughly screen for common genetic disorders, communicable diseases, and donor medical backgrounds (Almeling 2013; FDA 2010, 2018; Kramer 2016). It is also standard practice to conduct a semen analysis wherein pre- and post-thaw motility, morphology, and sperm counts are established. An evaluation of psychological health is increasingly incorporated into the screening practices promoted by mainstream commercial sperm banks (California Cryobank 2018, Seattle Sperm Bank 2018, Fairfax Cryobank 2018a, Xytex Sperm Bank 2018). While the American Society for Reproductive Medicine (ASRM) recommends that sperm banks conduct psychological evaluations on potential donors, sperm banks are not legally required to engage in such practices (Almeling 2011, 2013; Beer 2016). It is through this extensive testing, evaluation, and manipulation that commercial sperm banks can market their sperm as superior to “natural” and “fresh” sperm, which is presented to consumers as diseased, dysfunctional, and unpredictable (Mamo 2005, 2010; Moore 2007; Schmidt and Moore 1998). As new technologies and knowledges emerge within the assisted reproductive market and sperm donor market more specifically, they are integrated into and standardized within the donor screening process (Mamo 2010; Moore 2007; Schmidt and Moore 1998).

3.3 Self-Reflexivity in Sperm Donor Selection

In addition to the extensive screening procedures undertaken by commercial sperm banks, clients of donor sperm find additional ways to minimize risks when they engage in the donor selection process. In her research on how lesbians construct families via donor insemination, Laura Mamo (2005, 2010) examines how the donor choices of lesbians are rooted in mainstream understanding and acceptance of genetics and heredity. Within a biomedicalization era, she argues, genetics is increasingly understood to explain both health and illness (Mamo 2005, 2010). Furthermore, genetics have come to be widely understood as a means to potentially cure disease and illness (Clarke et al. 2003, 2010; Mamo 2005, 2010).

In applying such thinking, lesbian clients of donor sperm seek to reduce the potential risks to their future offspring by selecting donors whose genetics and medical backgrounds they consider to be the most ideal. When reviewing the donor medical and genetic backgrounds, lesbian clients often consider and reflect on their own health and family histories (Mamo 2005, 2010). In many cases, they will select donors who have traits or aptitudes that they believe may balance out their own perceived flaws (Mamo 2005, 2010). For instance, if a client is poor in math, or short, or has a history of Alzheimer's in her family, she will purposefully select a donor who excels in math, is tall, or has no documented history of Alzheimer's in his family. All of this is done in an effort to select (or deselect) the traits that they hope will be passed on to their progeny, making their child not only physically dominant, but potentially socially dominant as well (Daniels 2006; Mamo 2005, 2010; Schmidt and Moore 1998).

3.4 Data Collection

This study is a part of a larger project which sought to identify how various forms of inequality such as racism, classism, ableism, heterosexism, and homophobia are reproduced

within the donor insemination market. Examining both the marketing and the consumption of donor sperm, the project included 33 client interviews and 32 questionnaires,⁸ a content analysis of marketing materials from four major online sperm banks, and additional analysis of over 100 sperm donor profiles. The data under consideration here consists of content collected and analyzed from each of the four major online sperm banks, particularly focusing on content related to genetics and sperm donor screening practices.

For the purpose of this project, four online sperm banks were selected for evaluation: California Cryobank, Fairfax Cryobank, Xytex Sperm Bank, and the Sperm Bank of California. California Cryobank maintains its status as the largest sperm bank in the United States—it also has one of the most diverse donor pools available (California Cryobank 2018; Mroz 2012). Fairfax Cryobank, while slightly smaller, also has a diverse donor pool and provides donor content that is similar to that provided by California Cryobank; thus, making the content available from each bank more easily comparable. Xytex Sperm Bank was selected due to its inclusion of seemingly diverse working professional men and less restrictive educational requirements for donors. At the onset of this project, the company's available donor pool also included men with blue-collar type positions with more varied educational backgrounds. The Sperm Bank of California is the only remaining non-profit sperm bank within the United States (Moore 2007; SBC 2015). Since its inception, the Sperm Bank of California has catered to a clientele of single women and lesbians (Moore 2007; SBC 2015). While its donor pool is not as vast or diverse as the other three banks, including marketing materials from a non-profit organization that was founded on feminist principles served as a potential point of comparison

⁸ The researcher asked interviewees to complete an anonymous questionnaire on their sperm donor selection preferences. Participation was voluntary and of the 33 interviewees, one chose not to submit a questionnaire.

and analysis. Much of the analysis in this article centers on the three commercial sperm banks: California Cryobank, Fairfax Cryobank, and Xytex Sperm Bank. The marketing and discourses dealing with genetics and sperm donor screening are far more pronounced among the commercial sperm banks which use these services to actively promote their products. The non-profit Sperm Bank of California does engage in some of the same practices, but they are far less prominent and only emphasized in the case of necessity—not as standardized products or services that clients must purchase or pursue.

To effectively analyze materials from each of these online sperm banks' websites, I employed qualitative content analysis (QCA). Through the detailed and systematic process of coding data into relevant categories and themes, QCA enables researchers to describe the explicit and inferential meanings within a given body of written or verbal materials (Berg and Lune 2012; Cho and Lee 2014; Hsieh and Shannon 2005; Krippendorff 2008). In doing so, researchers gain meaningful insight into the social reality of the specific phenomena in question. This study includes a combination of both conventional and directed content analyses. Conventional content analysis is inductive in that researchers must immerse themselves in their materials so that categories can emerge from the data itself (Hsieh and Shannon 2005). Much like grounded theory, this approach allows the data to “speak to the researcher” rather than imposing a predetermined coding frame onto that data. It also prevents the researcher from limiting themselves to only focusing on existing theories and perspectives in the literature (Hsieh and Shannon 2005). Directed content analysis is deductive in that the researcher codes the data using pre-established theories and concepts within the literature to help frame their analysis (Hsieh and Shannon 2005).

Using these inductive and deductive approaches, I analyzed sperm bank marketing materials for emergent themes as well as those already guided by existing theories and research. Theoretical conceptions such as Schmidt and Moore's technosemen (Schmidt and Moore 1998) and the increasing influence of biomedicalization processes in the fertility market (Clarke et al., 2003; Clarke and Shim 2011; Mamo 2010) are particularly useful to help understand how the commercial sperm banking industry manages the marketing and selling of products and services, including and extending beyond the commodification of donor sperm.

3.5 Safety Not Guaranteed

One of the primary marketing strategies employed by the commercial sperm banking industry (as well as the larger reproductive market as a whole) is its focus on selling consumers hope (Becker 2000): hope for a child, hope for parenthood, and hope for a family. Within this narrative, consists the hope for a healthy donor, a successful conception and pregnancy, and the hope for a happy, healthy, intelligent, and successful child (Becker 2000; Daniels 2006; Kroløkke 2009; Moore 2007; Schmidt and Moore 1998). In the competitive industry of sperm banking, individual sperm banks promise clientele that with their elite donors and services, clients can achieve these aspirations. However, ever-present within these promises of hope and success are the potential threats facing consumers as they pursue this form of family planning. Indeed, a client may *not* become pregnant and if she does, she may have an unhealthy pregnancy or child. Despite all assurances—and there are many boasted by commercial sperm banks—when it comes to the genetic screening of sperm donors, there are no guarantees. California Cryobank (2018) advises potential clients:

No genetic testing has a detection rate of 100%. There will always remain a small possibility that a person could carry a mutation that is not detected by the testing performed. A residual risk is the chance that the donor could still have a genetic mutation for that condition even though the test result was negative or normal. A

normal or negative result indicates that the test did not detect any clinically significant genetic mutations or abnormalities for those specific conditions.

Genetic testing can reduce the chance for specific inherited conditions in a donor's offspring but it cannot eliminate the risks for those specific disorders or other untested conditions. In addition, there is always a 3 to 4% chance to have a child with a medical issue, regardless of the screening performed.

Within the contemporary reproductive market, those pursuing pregnancy are *always* at risk (Chadwick and Foster 2014; Lupton, 1999; Mamo 2010; Possamai-Inessedy 2006; Rothman 2014; Simonds, Rothman, and Norman 2013). In critiquing the prevalence of risk surveillance and management within the current reproductive market, Barbara Katz Rothman (2014) notes how there are no longer any healthy pregnancies and the best that one can hope for within this model of reproduction is a low-risk pregnancy. There are no exceptions for those seeking to become pregnant through donor insemination; they face a myriad of risks and many of those extend well before the pregnancy and any resulting child. Regardless of efforts to minimize those risks through donor screening, there is *always* a risk and there are no healthy donors, only "low-risk" donors:

We have pioneered for many years in genetic disease prevention. Our Cryobank is the only major bank which has full-time medical geneticists and genetic counselors on its staff to carefully screen potential donors for any family history or clinical manifestations of genetic illnesses. Furthermore, all donor candidates undergo the most extensive battery of genetic tests of any sperm bank, and all results are reviewed by our own genetics professionals. While the risk of genetic disease transmission can never be completely excluded, you can be confident that acquiring sperm from Fairfax Cryobank guarantees that this serious donor risk factor is reduced to the lowest level available anywhere (Fairfax Cryobank 2018a).

While simultaneously touting the highest of qualities possible for their donor pools, commercial sperm banks consistently embed a discourse of risk within their marketing. This marketing is situated at the crux of expert knowledges in science, technology, and medicine, with genetics playing one of the most significant roles. "Genetics have emerged as a key means through which

life is understood and by which disease can be cured,” further “cultural understandings of ‘health’ and ‘illness’ are increasingly geneticized and sperm banks have participated in promoting their services using these knowledges” (Mamo 2005: 250). Although clients may face “serious risks” in their pursuits of pregnancy and parentage, they can rest assured that the experts working for their chosen sperm bank have done everything possible to mitigate those risks. The juxtaposition of hope, fear, risk, and trust are ever-present and, without consumer faith in and acceptance of the legitimacy of these expert knowledges, such strategies would be ineffective.

In outlining their extensive sperm donor genetic screening practices, Xytex Sperm Bank assuages any potential concerns that clients may have, “Xytex genetic testing takes the mystery out of inheritance. Genetic testing allows you to choose confidently for your family.” On the company’s home page, a brief video loops on repeat wherein a white woman is depicted softly caressing the cheek of her (presumably) healthy, white newborn child (Xytex 2018: October). The following statement is imposed over the image: “A DECISION YOU WILL CHERISH FOR A LIFETIME: Sleep well knowing you’ve chosen well.” Just below this image and message is the phrase, “Steeped in Science, Rooted in Compassion,” followed by a list of board members’ credentials including but not limited to human genetics, infectious diseases, and reproductive endocrinology (Xytex 2018: October). Commercial sperm banks may actively heighten clients’ fears surrounding the potential threats of reproduction, but they also offer clients a sense of comfort. Yes, reproduction is risky; however, with the application of advanced technologies and medicine by their skilled and benevolent experts, clients should take comfort in their choice to use commercialized donor sperm.

3.6 Enhancing Technosemen and the Standardization of Expanded Carrier Testing

Although commercial sperm banks offer donor sperm what they proclaim is the “best of the best, at all times” (California Cryobank 2018), the extensive screening their standard donors go through may not be sufficient on its own. As prospective clients peruse the donor options at California Cryobank and Xytex Sperm Bank, they learn of specialized donors who have undergone even more expansive genetic screening. These donors are distinctive from the standard fare. For an extra fee,⁹ California Cryobank (2018) offers *DNA Advantage Donors*: “We now offer the most comprehensively screened sperm donors available. Our *DNA Advantage Donors* have been tested for 260+ genetic conditions. This comprehensive genetic testing helps identify donors who are the most suitable for you.” Xytex Sperm Bank (2018) offers a similar service in its *xyGene Donors* who have “undergone carrier testing for more than 170 genetic conditions.” *xyGene Donors* are marketed as an option for women who have undergone genetic screening and are known “carriers for conditions that most sperm donors are not tested.” However, any Xytex client could feasibly purchase a *xyGene Donor* without undergoing genetic screening herself. While traditional donors at these two sperm banks are presented as elite and high-quality, these specialized donors offer even more security to clients when it comes to calculating and minimizing genetic risk.

In addition to documenting medical histories and screening for communicable diseases, all sperm donors must receive a standard genetic panel (Almeling 2013; FDA 2010; Kramer 2016). Each of the four sperm banks analyzed for this project provide these basic screening services, including a three or four generation medical history background. Preconception carrier

⁹ As of April 2019, *DNA Advantage* donors cost approximately \$140 more than the standard-screened donors at California Cryobank (\$995 compared to \$855 respectively).

screening is meant to “identify couples at risk for passing on inherited genetic diseases to their children” (Fairfax 2018b). Traditionally, carrier screening has targeted a relatively low number of common genetic diseases, often focusing on high frequencies in ethnic subgroups such as sickle cell in African Americans (Fairfax 2018b; Lazarin and Haque 2016). Whereas the standard carrier screening of sperm donors may only include the most common genetic disorders, ranging from just a handful of diseases such as cystic fibrosis, muscular dystrophy, or Tay-Sachs to a panel of 30+ common genetic diseases (Xytex 2018), expanded carrier testing is far more extensive. Expanded carrier testing entails screening sperm donors for up to 200-300 genetic diseases and applies these tests across all racial or ethnic groups (Fairfax 2018b; Lazarin and Haque 2016). The specialized donors available through California Cryobank and Xytex Sperm bank undergo expanded carrier testing, receiving screening for 260+ and 170+ genetic diseases, respectively.

At the onset of this project, both Fairfax Cryobank and the Sperm Bank of California excluded any donor candidates determined to be carriers or those who exhibited any evidence of common diseases that are identifiable through standard carrier screening. The Sperm Bank of California (2018) continues this practice so that any potential donor who is identified as a carrier for any of the screened recessive genes, “is not accepted and we do not release any of his semen samples.” Fairfax Cryobank (2018a) previously had a similar policy, noting that “any candidate that is identified as a carrier or exhibits evidence of any of these diseases is not accepted into the donor program.” Alternatively, both California Cryobank and Xytex Sperm Bank, while providing expansive carrier screening for their specialized donors, continue to accept donors who *are* found to be carriers for certain recessive conditions. Where both the Sperm Bank of California and Fairfax Cryobank would outright exclude even carriers of common recessive

diseases, California Cryobank and Xytex Sperm Bank keep those donors available and either encourage clients to review the donor genetic testing summary with an expert (California Cryobank 2018) or prove that she herself is not a carrier of the same disease and has received genetic counseling (Xytex Sperm Bank 2018). Regardless of the sperm banks' policies, each policy serves to: highlight the significance of genetic inheritance in selecting an ideal donor, underscore the quality of each sperm banks' donors, emphasize the bank's commitment to protecting the client and her unconceived child, and venerate (and legitimize) the bank's techno-scientific medical screening practices.

During the analysis phase of this project, Fairfax Cryobank changed their donor screening practices, shifting to policies and practices that are similar, but not precisely like those enacted by California Cryobank and Xytex Sperm Bank. In August 2018, the website was updated to outline both the old and new screening practices, explaining to clients why the bank was moving to an "Expanded Carrier for All" policy. In an essay entitled, "It Is Time to Consider Expanded Genetic Carrier Screening for All Gamete Donors," the bank's Medical Director makes the case for: implementing expanded genetic screening for *all* donors (not just specialized donors); including donors who are carriers of recessive diseases; and requesting that clients also undergo expanded genetic screening so that her tests may be evaluated and contrasted with the sperm donor's results, thus enabling the bank to then provide a specific list of donors who are the client's best genetic matches. According to the Fairfax Cryobank (2018b) Medical Director, Harvey Stern, Ph.D.:

All sperm and egg banks carry out some form of genetic screening in their applicant selection process however, the extent of DNA-based genetic screening varies widely among gamete banks. In most but not all programs, carriers of recessive genetic diseases are excluded from being donors. This is based on the false assumption that a donor must be "perfect" and therefore a carrier of a genetic disease is not acceptable. This is not a rational argument as we are all

carriers of recessive genetic diseases. What matters is only which gene is involved and whether the reproductive partner is a carrier in the gene for the same disease as the donor. Otherwise they will be totally compatible from the genetic risk standpoint. It is intuitive that as screening becomes more and more effective that if all carriers are excluded, eventually there will be no donors available. Also, a donor who may not be compatible with recipient “A” would likely be totally compatible with recipient “B”. Adopting this approach would dramatically increase the number of available donors for selection.

The marketing of commercialized technosemen has *always* emphasized the exclusivity and high-caliber of donors, leaving little-to-no room for flaws—real or perceived (Daniels 2006; Kroløkke 2009; Mamo 2010; Schmidt and Moore 1998). However, the widespread acceptance and legitimization of genetics screening and its affiliated techno-scientific medical products and services have enabled commercial sperm banks to modify this narrative. Even though the donor may not be perfect and although he carries within him the potential to pass on genetic diseases, this risk can be minimized through the effective surveillance, identification, and management (treatment) by medical professionals. After all, “we are all carriers,” including the clients themselves. Through expanded carrier screening, commercial sperm banks promise clients a personalized experience wherein she is provided with a list of donors that are the best possible match for her—not only in physical, social, and personality traits, but also at the genetic level. As an added bonus, Fairfax Cryobank is able to increase the number of donors that it may offer. No longer restricted to excluding any and all carriers, this move enables the company to compete with similarly situated banks such as California Cryobank and Xytex Sperm bank by diversifying its donor pool and touting scientific and medical excellence via advancing donor screening services.

3.7 It Takes Two, Baby

As commercial sperm banks maximize the ability and scope of technosemen to address the risks associated with reproduction, the industry is also identifying new avenues of revenue that

will both detect and reduce reproductive risks. The industry's reliance on medicalized discourses of genetics and reproductive risk has traversed beyond technosemen and into the realm of client-based screening services. If genetics plays a significant role in the management of risk reduction, then accounting for the genetic makeup of *both* biological contributors must be imperative. California Cyrobank's expanded carrier screening services are similar to that of Fairfax's new policy and practice. Although all clients do not have to undergo genetic carrier screening, the option is presented as ideal since it provides clients with the information they may need to make an informed decision about their donor. Indeed, "It's easy to find a compatible *DNA Advantage Donor* when you know your carrier status and have the donor's genetic results at your fingertips!" California Cryobank 2018).

YOUR DONOR'S DNA IS ONLY A PIECE OF THE PUZZLE

Your DNA is also important to consider. All people carry mutations for autosomal recessive genetic conditions. (Believe it or not, it's "normal" to carry mutations!) You're not at risk to have a child with one of those conditions unless you and your donor both carry a mutation for the same condition.

DONOR'S TEST RESULTS

It's important to view your donor's **Genetic Test Summary (GTS)** to understand which genetic conditions he was tested for and his results. Not all donors have been screened for the same conditions. Before you pick up or ship vials, **we recommend reviewing your donor's GTS with your physician.** You may also need to sign an acknowledgement.

[See a sample of a Genetic Test Summary](#)
[View Example](#)

YOUR TEST RESULTS

Expanded genetic testing is covered by most insurance plans. You may have already had it done. If not, we recommend speaking to your physician to see if testing is right for you. If you know you carry a mutation for a specific genetic condition and a donor was not screened for that condition, we may be able to do **special testing** on the donor.

[> Learn more about special testing](#)

It's easy to find a compatible DNA Advantage Donor when you know your carrier status and have the donor's genetic test results at your fingertips!

Figure 1. California Cryobank (2018), Piece of the Puzzle

Whereas commercial sperm banks assert the high quality and safety of their donors, the client is an unknown factor and therefore, poses a significant risk herself. Fairfax Cryobank

(2018a) highlights how unpredictable and therefore, how unsafe a client's unknown genetics can be:

Usually people do not know they carry a recessive gene, unless they have a child or another family member who is affected. However, 80% of couples who have a child with a recessive genetic disorder have no family history of the condition.

A client may believe that she is in good health and that she knows her family medical background well. Commercial sperm banks instill a sense of uncertainty and fear that anyone could carry a malignant gene, quietly waiting to emerge in the genetic makeup of one's child. Ultimately, it is paramount that a potential mother-to-be obtain as much information as possible to minimize potential genetic risks and ensure the safety of her pregnancy and child. To engage in this process effectively, she must not only obtain information about her own genetics through her own expanded carrier screening, she should also consult with an expert—either with her own physician or a genetic counselor. California Cryobank (2018) outlines what steps clients can take to “reduce the risk for birth defects” in a child:

Although we screen our donors to help reduce the risk for medical issues in donor offspring, it is important for all clients to speak with their physician and/or genetic counselor about their own family histories. A child inherits 50% of his or her DNA from each parent. Many clients may not know that they have an increased risk to have a child with medical problems unless they have a thorough family history evaluation. CCB recommends that all clients meet with a genetic counselor to evaluate their own family medical histories and discuss genetic testing options that are appropriate for their needs.

All four sperm banks—commercial and non-profit alike—emphasized the importance of clients consulting with a genetic counselor or physician before finalizing their donor selections. Three of the sperm banks refer clients to their in-house genetic counselors for consultation regarding the donor: California Cryobank, Fairfax Cryobank, and the Sperm Bank of California. At the time of analysis, Xytex Sperm Bank did not have in-house genetic counselors. Instead the company referred clients to a third-party company by the name of Counsyl which provides expanded

carrier screening for individuals and couples planning to conceive a child. Commercial sperm banks encourage clientele to consult with these specialists to review their donor's medical and genetic background and to consider how their own genetic results should be considered in relation to their prospective donors' genetics. However, a distinct difference was present in how the non-profit Sperm Bank of California presented the option of genetic counseling services and its relation to clients obtaining genetic screening. Rather than marketing genetic screening for any and all clients as paramount, the Sperm Bank of California only indicated that genetic screening should be an option if the client were first identified as being "high-risk" by a genetic counselor.

Commercial sperm banks engage in additional risk management as they attempt to prevent clients from selecting a donor that might be identified as a poor match at the genetic level. Xytex Sperm Bank advises clients who receive genetic screening, "If you and the donor are found to have the same gene marker, you have options." The bank's site then instructs clients that they are able to either select a different donor or meet with a genetic counselor to determine whether the child might have health problems because of the gene marker. Clients who test positive for a genetic disease must either prove they are not carriers or that they are at reduced-risk. They can do this by undergoing genetic testing and speaking with their physicians or genetics counselor. If a client chooses to use donor sperm from a donor who has a known carrier status, she must sign an acknowledgement and/or waiver. Doing so covers sperm banks legally in the event that a child is born with significant health problems connected to genetic inheritance. These policies were explicitly articulated by California Cryobank, Fairfax Cryobank, and Xytex Sperm Bank. Since the Sperm Bank of California does not include donors who test positive, such policies are not necessary.

Client screening and genetic counseling services enable clients of donor sperm to engage in new forms of reproductive preventative care that extend well before conception is even arranged. Just as pregnant women face significant pressure to surveil, calculate, and minimize the potential risks which threaten their pregnancies and unborn children (Lupton 1999; Possamai-Inessedy 2006; Rothman 2014), so too do clients of donor sperm. Commercial sperm banks identify a myriad of risks that a client can consider and manage at the pre-conceptive stage in order to prevent the potential birth of a child afflicted by genetic disease, disorder, or disability. Through her interactions with online commercial sperm banks, a client learns that she poses one of the most significant threats. Just as sperm banks frame natural semen as “dirty, diseased, and broken” (Schmidt and Moore 1998; Moore 2007), similar treatment is given to the unknown, untested genetics of clients. In a culture that places the burden of reproductive responsibility onto mothers and women’s bodies (Lupton 1999; Rothman 2014; Simonds, Rothman, and Norman 2013), clients of donor sperm face potential scrutiny for failing to heed the warnings of the commercial sperm banking industry.

Online sperm banks market themselves as having done everything within their power to reduce the risks of donor sperm itself. In identifying the client as a potential risk while also offering a solution to minimize that risk via various genetic screening and counseling services, the sperm banking industry shifts the responsibility of risk-reduction and the achievement of health onto the shoulders of the client. Should a client fail to take these steps, then she does so knowingly. Medical sociologists argue that in an industry such as this, health is not only something that can be purchased and pursued; rather, it is treated as a “social and moral responsibility” that can and must be obtained through biomedical interventions (Clarke et al. 2003; Mamo 2010). Therefore, if a child is born with a genetic disease or disability that could

have potentially been prevented through the industry's screening and counseling services, then it is through the mother's own negligence. Within a market such as this, good mothering begins well before conception, achievable via a biomedicalized consumerism wherein aspirational mothers-to-be attempt to purchase the health, intellect, and aptitude of their future progeny.

3.8 Discussion

Relying on a discourse of risk and supported by an increasingly biomedicalized reproductive industry, online sperm banks have expanded their services beyond the scope of offering mere donor sperm. By leveraging the rapid advancement of genetics-based knowledges and reproductive technologies, online sperm banks upsell existing products such as technosemen while reaching new avenues of revenue through client-based screening and genetic counseling services. In this study, I document how online sperm banks' marketing of aspirational parentage is underpinned by discourses of fear, risk, and techno-scientific medical excellence. Clients are made to fear the countless risks posed by communicable and heritable diseases. It is only through the application of innovative screening procedures and the dedication of scientists and medical experts—in the employ of these companies—that clients of donor sperm can rest assured that their hopes of producing a healthy child can be achieved.

All these efforts serve to encourage and assist clients of donor sperm in producing the best possible outcome: a healthy child who is unburdened by genetic, physical, or mental diseases and disorders. In commodifying health in this way, the sperm banking industry also commodifies the propagation of privilege, enabling those who have the ability and resources to participate in the evolving reproductive market to purchase the health of their child. In a society plagued by vast inequities, including health disparities and their related oppressions and privileges, clients of donor sperm have an opportunity to purchase the privileges associated with good health for their

children. To be in good health—mentally, physically, and genetically—is to be privileged. In a market that frames the achievement of health as overcoming the myriad of genetic and reproductive risks facing clients, “risk” cannot be untangled from vast and intersecting systems of inequality. While sperm banks may overtly represent “risk” as an issue of health, it is also an issue of passing on power and privilege to one’s child and family. To strive for a low-risk donor, a low-risk pregnancy, and a low-risk child is to strive for experiencing a low risk of inequity—one that can be obtained via commercialized reproductive care. The long-term potential for disparities is great, as those with the means to do so will purchase the newest and most innovative techniques to ensure the creation of a healthy, privileged child.

It is unsurprising that those aspiring to build a family would use the resources available to them in order to ensure that their child live a life unburdened by health-related barriers or discrimination. Indeed, our society continues to fail at effectively providing all people, regardless of their station or ability, access to quality and affordable medical services. Furthermore, the day-to-day and structural barriers faced by those living with physical and mental illness are seemingly infinite. Online sperm banks offer clients an array of simple products and services that may have the potential to significantly reduce the likelihood of disability and disease, thereby reducing associated barriers for clients’ children and families. As new knowledges and technologies evolve, they too will be integrated into the services offered by the sperm banking industry—enabling clients of donor sperm to seemingly control more aspects of their prospective child’s quality of life. The efficacy of genetic screening and counseling in reducing the likelihood of disability and disease within the sperm donor market is indeterminate; as has been documented here, sperm banks themselves explain that genetic testing cannot guarantee that a

child will not be born with a genetic disease or disorder. Nonetheless, these medical services provide clients of donor sperm with the sense that they do have control over such matters.

Although this study focuses on genetic screening and counseling services within the donor insemination market, it is not far-fetched to assume that these same procedures will be promoted and integrated within the broader reproductive market. Indeed, the third-party company Counsyl, hired by Xytex Sperm Bank, offers expanded carrier screening services for *any* individuals and couples pursuing pregnancy. One need not participate in the assisted reproductive market to obtain such services. Further, as genetic screening services such as DNA test kits become more popular, it is likely only a matter of time before expansive genetic screening and counseling services are integrated as standard practice in reproductive care. So long as the reproductive process is commodified, framed in terms of risk (Chadwick and Foster 2014; Helén 2004; Lennon 2016; Lupton 1999; Rothman 2014; Simonds, Rothman, and Norman 2013), and looks to new technologies and knowledges for solutions to those risks, then practices such as genetic screening and counseling will only proliferate.

Disability scholars contend that these efforts are meant to eradicate certain populations from existence (Asch 2003; Daar 2017; Ne'eman 2015; Oullette 2015; Saxton 2006). Indeed, prenatal testing procedures such as those that identify the likelihood for Down Syndrome in fetuses are already standard practice in the United States, although rates of termination are significantly lower than what is documented in other parts of the world (Natoli et al. 2012; Quinones and Lajka 2017). Current IVF practices enable prospective parents, with the guidance of their physicians, to select which embryos are deserving of implantation (Brezina, Kutteh, Bailey and Ke 2016). Research on genetic counseling consistently documents how the field and its practitioners seek to employ their services to prevent genetic disabilities and diseases in

patient offspring (Bernhardt, Kellom, Barbarese, Faucett and Wapner 2014; Ciske, Haavisto, Laxova, Rock, and Farrell 2001). Genetic screening and counseling services enable prospective parents to identify some potential risks of disease or disability *well before* conception occurs. Therefore, these procedures have the potential not only to prevent the births of children with certain diseases or disabilities, they have the potential to prevent such persons from ever being conceived. As the capacities of reproductive technologies reach into earlier stages of the reproductive process, so too will the debates around disability rights, reproductive choice, and the ethics of genetic science in determining which traits are deemed too “risky” to pass on to future generations. The future composition of society and its members will be shaped by these conversations. And while striving for health may be a noble cause, it is necessary to examine the extent to which these technologies and services are applied by individuals and institutions. Academics and activists alike must engage in these conversations, challenging those who shape reproductive policy and practice to consider how those applications may create further disparities in health, quality of life, and opportunity.

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4 THE GOOD, THE BAD, AND THE UGLY: EXPLORING THE EUGENIC IMPLICATIONS OF SPERM DONOR SELECTIVITY

*“With over 40 years of trusted experience and the **highest quality** commitment in the industry, Xytex is here to ensure that your decision is one that you’ll cherish for a lifetime. That’s why we offer you the donor sperm that is **the industry’s most selective and most successful**.”—Xytex Cryo International (2018)*

*“Donor Recruiters actively pursue **highly educated and accomplished students and professionals** as potential donors. Our Donor Coordinators, Professional Laboratory Staff and Genetic Counselors then begin the screening process, ultimately **eliminating all but the top 1% of applicants**, assuring you the **highest quality donors** to choose from.”—California Cryobank (2018)*

*“The screening process is intentionally designed to be **rigorous** and **exclude any applicant** that does not meet our industry leading standards. **Less than 1% of donor applicants are accepted...**”—Fairfax Cryobank (2018)*

In perusing the websites of sperm banking industry leaders, potential clients are immediately met with proclamations of quality, safety, and exclusivity. Hopeful clientele take comfort in these assertions, wherein the decision to move forward with *any* sperm donor is marketed as a correct one. If all available donors are the best of the best—the top 1% even—then any choice is surely acceptable. In addition to assurances of desirable motility and sperm count, sperm donors are marketed as college-educated, attractive, successful, talented, and supremely healthy (Kroløkke 2009; Moore 2007; Schmidt and Moore 1998). Given such marketing, imagine the surprise of British couple Angela Collins and Margaret Elizabeth Hanson when they learned that their son’s sperm donor was not the “genius-level” neuroscience Ph.D. student they believed him to be (Beer 2016; Hauser 2016; Lewin 2016).

After learning of the donor’s identity in an accidental breach of confidentiality by Xytex Corporation in 2014, the couple soon discovered that the information regarding Donor 9623,

Christian Aggeles, was not remotely accurate (Hauser 2016; Lewin 2016; Rankin 2016). Aggeles was not an aspiring neuroscience engineering Ph.D. student; he had dropped out of college and had no college degrees while donating for Xytex (Beer 2016; Hauser 2016; Lewin 2016; Lindstrom 2017; Rankin 2016). While his donor profile indicated that he had a healthy family and medical history, Aggeles had a history of documented psychiatric hospitalizations and diagnoses of schizophrenia, bipolar, and narcissist personality disorders (CBS News 2015; Hauser 2017; Lewin 2016; Rankin 2016). Furthermore, Aggeles had been arrested and imprisoned for burglary during his tenure as a Xytex donor (Lindstrom 2017). However, his conviction was later cleared under the state of Georgia's First Offender Act (Hauser 2016; Lindstrom 2017).

Confronted with multiple lawsuits alleging that the company was negligent and fraudulent, Xytex Corporation argued that there had been no wrongdoing (Beer 2016; Hauser 2016; Lewin 2016; Lindstrom 2017; Rankin 2016). Indeed, Xytex Corporation had acted in-line with sperm banking industry standards (Kramer 2016; Lewin 2016; Rankin 2016). Sperm banks are required by the Food and Drug Association (FDA) to thoroughly screen for common genetic disorders and communicable diseases (Almeling 2013; FDA 2010; Kramer 2016). The American Society for Reproductive Medicine (ASRM) also encourages similar screening, going even further by recommending psychological evaluations of donors (ASRM 2013). However, sperm banks are not legally required to adhere to the guidelines outlined by the ASRM (Almeling 2011, 2013; Beer 2016), nor are they required to validate the personal and medical information supplied by donors (Kramer 2016; Lewin 2016; Rankin 2016).

There are very few rules when it comes to the formal regulation of the sperm industry and the reproductive market more broadly (Almeling 2011, 2013; Cahn 2009; Cahn and Kramer

2011; Kramer 2016). Sperm banks are not required to run personal or criminal background checks, nor must they review a potential donor's personal and family medical files (Beer 2016; CBS 2016; Kramer 2016; Lewin 2016; Lindstrom 2017). Instead, sperm banks rely on donor self-reporting for any personal, criminal, or medical information (Beer 2016; Kramer 2016; Lewin 2016). Ultimately, Xytex Corporation was under no legal obligation to prove that the information provided by the donor was accurate. Several families filed lawsuits against the bank and donor in question; damages for negligence, funds for future medical expenses due to hereditary mental illness, and reform of industry standards were at the forefront of these cases (Hauser 2016; Lindstrom 2017). In the fall of 2017, Xytex Corporation settled the cases out of court, leaving industry standards as they are (Lindstrom 2017). However, in the aftermath of these widely publicized court cases, a handful of sperm banks have begun offering criminal background checks and educational transcript verification—Xytex included (California Cryobank 2018; Lindstrom 2017; Seattle Sperm Bank 2018).

At the core of these cases lies the belief that Christian Aggeles should not have been allowed to donate sperm—that his lack of educational attainment and mental health should have prevented him from making it into the final donor pool. The clients, their lawyers, and the media point to his criminal background as further exemplifying his undesirability as a donor. The sperm banking industry bases its marketing on the notion that only a handful of men are worthy of selection and that the men who are worthy will pass on their most ideal traits—health, appearance, genetics, skills, and aptitudes. Each bank proclaims that their specific screening processes are those that result in the most exceptional donors. Their donor exclusivity and quality—determined by a variety of measures such as genetics, medical background, educational attainment, physical traits, and multiple social markers of “success”—are at the crux of

commercial sperm bank marketing (Daniels 2006; Kroløkke 2009; Moore 2007; Schilt and Moore 1998; Tober 2001). Unsettling questions arise when considering the moral and ethical implications of such proclamations. For instance, who is allowed to participate in this market? What kinds of men are identified as ideal donors, and who make the final cut? Which men are excluded from donation or client selection? On what basis do individual clients determine whether a prospective donor is “fit” or “unfit” for selection? Perhaps the most unsettling questions are those that are rooted in each of these: Who is considered to be worthy of procreation and, who is not?

Such questions serve as the foundation for this article. Using interview data with women who went through the process of selecting a sperm donor from an online sperm bank, I examine how clients of donor sperm, supported by dominant beliefs about genetics and heritance, reify eugenic values and practices through their individualized donor choices. *Eugenics* is the belief that the human race and society as a whole could be improved through selective breeding (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Hix 2009; Lombardo 1996; Suter 2007). In identifying the characteristics of potential donors that they deem to be desirable or undesirable, they reinforce ideologies similar to those once promoted by advocates of the early American eugenics movement. Although the individual choices of clients of donor sperm are a far cry from authoritarian, state-sponsored sterilization and institutionalization programs (Daar 2017; Suter 2007), the underlying ideologies about who should be left out of the reproductive market are promoted at the cultural level, often by powerful institutions that control the production of reproductive knowledge (Hubbard 2006). Much of the research on how eugenic practices prevail within the contemporary reproductive market center around institutional level analyses—how the industry itself promotes modern-day eugenics (Daar 2017; Hix 2009;

Hubbard 2009; Lombardo 1996; Ne'eman 2015; Suter 2007; Saxton 2006). In this study, I examine how individuals who participate in the donor insemination market respond to the eugenic values and practices that are entrenched within this industry. Clients of donor sperm are often aware of the underlying eugenic values embedded within the process of sperm donor selectivity. Although they often problematize the underlying morality of those values, they nonetheless reify those values by choosing donors who can produce children most likely to live privileged lives.

4.1 Sperm Sells

Prior to the widespread commercialization of the U.S. sperm banking industry, the responsibility of selecting a sperm donor primarily fell to one's physician (Almeling 2011; Barney 2005; Becker 2000; Mamo 2005, 2007). Most practitioners relied on the fresh sperm donations of their medical students, hospital personnel, or university students and staff (Almeling 2011; Mamo 2005, 2007; Moore 2007). These men were considered to be the best and brightest possible donors; they were white, healthy, intelligent, talented, and successful (Almeling 2011; Mamo 2005, 2007; Moore 2007). These qualities remain central to the industry's contemporary marketing and profit-making strategies (Daniels 2006; Kroløkke 2009; Moore 2007; Schilt and Moore 1998). Commercial sperm banks actively work to present their product as embodying the traits, attributes, and aspirations of the individual donors themselves (Daniels 2006; Kroløkke 2009; Moore 2007; Schilt and Moore 1998; Tober 2001).

Rather than advertising donor sperm as mere biological matter, capable of helping one achieve pregnancy, clients are asked to imagine real men who possess the physical, genetic, and social qualities necessary to produce a healthy, intelligent, and successful offspring (Daniels 2006; Kroløkke 2009; Moore 2007; Schilt and Moore 1998; Tober 2001). A vial does not contain

bodily materials; it consists of the very man who donated those cells. In this way, clients are encouraged to believe that they are buying a college-educated, six-foot, engineer, with straight teeth, blonde hair and blue eyes, and who spends his spare time playing lacrosse and volunteering for the local *Boys and Girls Club*. Although most people recognize attributes such as personality, interests, occupations, and life aspirations as non-heritable (Scheib 1994; Scheib, Kristiansen, and Wara 1997; Tober 2001), the information is presented so as to make clients feel that it does matter and will somehow result in a child with similar qualities and abilities (Daniels 2006; Kroløkke 2009; Moore 2007; Schmidt and Moore 1998; Tober 2001).

Additionally, sperm banks promote each individual donor as unique and distinct from the next. In doing so, they reify hegemonic ideologies regarding masculinity and manhood (Moore 2007; Schmidt and Moore 1998). According to Schmidt and Moore (1998), when sperm banks highlight the differences between donors, they make apparent the hierarchies that exist among men in general. While donors vary in their individualized qualities, they all meet dominant standards of hegemonic masculinity—they are tall, healthy, athletic, intelligent, and successful. They also tend to be either competent or highly skilled in a variety of trades, hobbies, and interests which are consistent with cultural standards and expectations of “appropriate” masculinity (Daniels 2006). By identifying these traits and abilities as desirable in sperm donor profiles, the banks promote a specific form of masculinity that is then packaged and marketed to clients who are looking to purchase the best possible man for the job (Daniels 2006; Kroløkke 2009; Moore 2007; Schmidt and Moore 1998; Tober 2001). Indeed, each donor is advertised as the perfect man.

Those men who don’t meet the industry standards are either not allowed to participate in sperm donation, or they are weeded out during the strict screening process. California Cryobank

(2019) boasts that its screening process is so rigorous that “less than 1% of applicants” make it into their donor program. In effect, they lack the traits necessary to be included in the elite donor pool. Given that banks venerate those donors who meet dominant conceptions of what it means to be a good, worthy, and successful man, presumably those men who are excluded are deficient, lacking, and somehow “less than” those who do make the cut (Daniels 2006; Moore 2007; Schmidt and Moore 1998). Furthermore, such men are understood as possessing the physical, genetic, and social qualities that could lead to the birth of a child who is *less* healthy, *less* intelligent, and *less* successful.

4.3 In Pursuit of the “Well-Born”: A Brief Discussion of the American Eugenics Movement

In an op-ed for *The Guardian*, autistic activist and advocate Ari Ne’eman (2015) contemplates how advancements in reproductive technology are being used to remove people like him from the population. Autism, like many disorders or disabilities, is generally recognized in our society as undesirable or at least not preferred—as something we should treat and prevent (Ashe 2003; Gejman, Sanders, and Duan 2010; Malek 2010; Ne’eman 2015; Rees, O’Donovan, and Owen 2015). When medicine and technology enable scientists to identify genetic markers for diseases and disorders such as schizophrenia or autism¹⁰ (Gejman et al. 2010; Ne’eman 2015; Rees et al. 2015), they create new ways to screen and filter those populations from the reproductive market (Daar 2017; Ne’eman 2015; Oullette 2015). Ne’eman (2015) poses the question: What might we potentially lose when we remove certain populations from the

¹⁰ However, scientists studying genetics and genetic markers of disease such as these also highlight that the genetic markers linking to certain diseases are incredibly complex and multi-faceted; it is therefore difficult to pinpoint specific genes associated with genetic diseases (Rees et al. 2015).

reproductive market and ultimately, from future generations of humanity? Further, what might humanity look like without the contributions of those communities (Ne’eman 2015)?

As the reach of reproductive technologies expands, so too does our ability to select the traits of donors and embryos alike (Daar 2017; Moore and Grady 2014; Ne’eman 2015; Oullette 2015). While proponents of this level of selectivity hail such technologies and their ability to expand our “reproductive choices” (Malek 2010; Savulescu 2001), others are hesitant—fearing just how eugenic these choices will be (Asch 2003; Daar 2017; Hubbard 2006; Oullette 2015; Parker 2007; Suter 2007). Ruth Hubbard (2006:102) contends that we veer exceptionally close to our eugenic heritage when we “let scientists and physicians make judgments about who should and who should not inhabit the world and applaud them when they develop the technologies that let us implement such judgments.”

Eugenics gained popularity in the United States during the late 19th and early 20th centuries (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Hix 2009; Lombardo 1996; Suter 2007). Experts point to several social and economic factors that supported the proliferation of eugenic ideology in the United States: post-Civil war era turmoil (Bosch 2007), including the continued relevance of white supremacist ideology and the desire to maintain white racial purity (Daar 2017; Roberts 1997); the swift transition from an agricultural-based economy towards industrialization and urbanization (Allen 1997; Bosch 2007); and cities that were ill-prepared to provide for an expanding population, including significant waves of immigrants to those cities (Allen 1997; Bosch 2007; Daar 2017). Ultimately, the era was rife with political, social, and economic unrest (Allen 1997; Bosch 2007).

Coinciding with this societal turmoil, the emerging science of genetics was gaining popularity among scientists, political leadership, and the general public (Allen 1997; Bosch

2007; Daar 2017, Lombardo 1996). Of particular significance was the Mendelian theory of inheritance which posited that complex human traits are passed down from parent-to-child by just a handful of genes (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Lombardo 1996; Suter 2007). Eugenicists embraced Mendelian genetics, further arguing that many of society's problems could be explained with genetic determinism (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Hix 2009; Lombardo 1996; Suter 2007).

According to Paul Lombardo (1996), eugenic ideology of the day followed three primary tenets:

1. "Social moral, physical, and mental qualities are transmitted in predictable patterns by the mechanisms of heredity.
2. The human race can be improved by selective mating.
3. The ills of society can be eradicated by discouraging, or preventing if necessary, the reproduction of socially deviant individuals (3-4)"

If societal ills such as poverty and crime, or those leading to dysfunction and inefficiency (e.g., disability, disease, addiction, and social dependency) were rooted in the genetic traits of the populace, then those problems could be solved by controlling the reproduction of the American people (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Hix 2009; Lombardo 1996; Roberts 1997; Suter 2007). In solving these problems, eugenicists argued that they could improve the collective quality of life and reduce the social costs associated with populations they deemed undesirable (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Hix 2009; Lombardo 1996; Roberts 1997; Suter 2007).

In practice, these ideologies took the form of *positive* and *negative eugenics*. Positive eugenics, put simply, promotes the reproduction and union of those citizens deemed "genetically superior" (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Lombardo 1996; Roberts 1997; Suter 2007). Conversely, negative eugenics attempts to reduce or altogether prevent procreation between those deemed "unfit" (Allen 1997; Bosch 2007; Burke and

Castaneda 2007; Daar 2017; Lombardo 1996; Roberts 1997; Suter 2007). Harry Laughlin, American eugenicist and Director of the New York-based Eugenics Record Offices defined the unfit as: “the feeble-minded, the insane, the criminalistic, the epileptic, the inebriated or the drug addicted, the diseased—regardless of etiology, the blind, the deaf, the deformed, and dependents” (Lombardo 1996: 3). Dependents were a broadly defined group, consisting of orphans, the homeless, “tramps,” “paupers,” and the “ne’er do wells” (Daar 2017; Laughlin 1914; Lombardo 1997).

The majority of eugenic practices in the United States primarily took the form of negative eugenic policies (Bosch 2007; Burke and Castaneda 2007; Daar 2017; Lombardo 1996). In addition to institutionalizing and sterilizing tens of thousands of Americans, eugenicists were particularly effective at lobbying for anti-immigration policies (Bosch 2007; Burke and Castaneda 2007; Daar 2017; Lombardo 1997). These efforts were meant to separate the “socially unacceptable” from the general population—particularly during their reproductive years (Bosch 2007; Burke and Castaneda 2007; Daar 2017; Lombardo 1997). Eugenicists firmly believed in genetic determinism. As such, their policies and practices were rooted in ideologies that failed to account for the role of social, economic, and environmental determinants of social problems like poverty, disease, physical and mental illness, addiction, and social dependency (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Roberts 1997; Suter 2007). In successfully promoting the belief that these problems could be solved with eugenic practices (Allen 1997; Bosch 2007; Burke and Castaneda 2007; Daar 2017; Lombardo 1996), eugenicists were able to effectively enact a myriad of policies that pushed for the removal of the diseased, the disordered, the disabled, and the “degenerates” of society. All of these efforts were implemented with the goal

of improving the quality of life for future generations and in doing so, improving society and humanity as a whole.

4.4 Reproductive Technologies and the New Eugenics

Several decades have passed since classical eugenics fell out of favor. The decline of eugenics' popularity is often attributed to Nazi extremist implementation of eugenic ideologies via mass genocide (Bosch 2007; Burke and Castaneda 2007; Suter 2007). However, new knowledges and practices within science, technology, and medicine propel the ability and scope of reproductive technologies forward—causing both concern and debate around the implementation of those technologies (Asch 2003; Daar 2017; Hubbard 2006; Oullette 2015; Saxton 2006; Suter 2007). In particular, critics point to the ways in which reproductive technologies can and are being used in eugenic ways (Asch 2003; Daar 2017; Hubbard 2006; Oullette 2015; Saxton 2006; Suter 2007). Disability scholars and activists are some of the most vocal critics, arguing that genetic testing and reproductive technologies are ultimately being used to identify and prevent the births of disabled persons (Asch 2003; Daar 2017; Ne'eman 2015; Oullette 2015; Saxton 2006). Elsewhere, I argue that genetic testing and counseling services are being leveraged within the donor insemination market in ways that prevent even the fertilization of cells that could produce children with genetic disorders, diseases, or disabilities (Tesene 2019). Marsha Saxton (2006) notes the irony of such practices coinciding with social and political advancements in disability rights and inclusion.

Those who advocate for the use of genetic testing and reproductive technologies in procreative care often challenge associations with the classical American eugenics movement (Daar 2017). Rather than coercive, state-sponsored measures to promote “good-births,” they argue that the new eugenics—dubbed *neoeugenics*—takes place at the individual-level whereby

potential parents make personal choices regarding their future offspring (Daar 2017; Suter 2007). Whereas some proponents go as far as to argue that it is a parent's moral obligation to use the information and technology available to them so as to ensure their child has the best possible life, void of any diseases, disorders, or disabilities (Savulescu 2001), others argue that electing to use or not use reproductive technologies in this manner is a matter of reproductive liberty and parental choice (Agar 2004; Steinbock 2002). Prospective parents, they claim, should have the right to control their reproduction—including the use of all available information and technology to make the most informed decision about whether to move forward with a pregnancy or not (Agar 2004; Daar 2017; Steinbock 2002). According to proponents of this thinking, using that information to determine whether or not to terminate a pregnancy is a matter of reproductive liberty and not necessarily a devaluation of those currently living with disabilities (Agar 2004; Malek 2010; Steinbock 2002). Critical disability scholars and activists disagree (Asch 2003; Ne'eman 2015; Oullette 2015; Saxton 2006).

4.5 An Increasingly Biomedicalized Reproductive Market

Medical sociologists contend that, since the 1980s, we have entered a biomedicalization era wherein social transformations such as privatization, commodification, neoliberalization, technoscientization, and new forms of knowledge production and dissemination are vastly reshaping the health sector in the United States and abroad (Clarke, Shim, Mamo, Fosket, and Fishman 2003; Clarke and Shim 2011; Clarke, Mamo, Fosket, Fishman, and Shim 2010; Mamo 2005, 2010). They argue that the once prominent “medical industrial complex” (Ehrenreich and Ehrenreich 1971) has been replaced with what Clarke et al. (2003, 2010) refer to as the Biomedical Technoservice Complex, Inc. “This concept emphasizes the corporatized and

privatized (rather than state-funded) research, products, and services made possible by technoscientific innovations that further biomedicalizations” (Clarke et al. 2003: 167).

As scientific and technological innovations hybridize, they establish new forms of knowledge, practices, and techno-services (Clarke et al. 2003, 2010; Clarke and Shim 2011; Mamo 2010). This is particularly true in the area of human genetics, which is increasingly understood at the cultural level and applied as a personalized pathway for achieving health (Clarke et al. 2003, 2010; Mamo 2010). Medical knowledges are far more accessible, through mediums such as the internet and news media; and privatized technoscience and pharmaceutical industries have emerged as “legitimate” producers and disseminators of knowledge (Clarke et al. 2003, 2010; Mamo 2010). Mamo (2010) further argues that with increasing acceptance of neoliberal ideology, individual responsibility in establishing and maintaining one’s own health has become paramount in the reproductive market. Within this market, health is a commodity that individual consumers can and *must* pursue through ever-expanding customizable products and services (Mamo 2010).

4.6 Data Collection

This study is a part of a larger project which sought to identify how various forms of inequality such as racism, classism, ableism, heterosexism, and homophobia are reproduced within the donor insemination market. Examining both the marketing and the consumption of donor sperm, the project included 33 client interviews and 32 questionnaires,¹¹ a content analysis

¹¹ The researcher asked interviewees to complete an anonymous questionnaire on their sperm donor selection preferences. Participation was voluntary and of the 33 interviewees, one chose not to submit a questionnaire.

of marketing materials from four major online sperm banks,¹² and additional analysis of over 100 sperm donor profiles. The data under consideration here consist primarily of content collected through 33 interviews with women who spoke about the beliefs and actions that guided their donor selection process. In particular, I focus on clients' discussions of heritability, desirable and undesirable traits, and which men should (or should not) be included in the sperm donor market. I also examine how clients of donor sperm articulated feelings of unease associated with their determinations, which often conflicted with their self-ascribed progressive politics. Where appropriate, I also integrate supporting content analyzed from the online sperm banks.

To be included in the study, interviewees must have gone through the process of selecting a sperm donor from an online sperm bank. Recruitment consisted of convenience sampling through personal and professional networks, and outreach to fertility clinics, online forums, blogs, and Facebook communities targeting those seeking pregnancy through donor sperm. Although inclusion was not limited to female-bodied or women-identified individuals, interviewees primarily¹³ fell into two main categories: (1) Lesbians and queer women in relationships with cis women or trans men; and (2) single mothers by choice who primarily identified as heterosexual. Of the 33 interviewees considered here, 30 identified as white. The remaining three identified as Puerto Rican, Japanese, and Biracial. Respondents were overwhelmingly liberal, college educated, and professional women with household incomes placing them in the middle- to upper-middle-class range.

¹² Four online sperm banks were selected for evaluation: California Cryobank, Fairfax Cryobank, Xytex Sperm Bank, and the Sperm Bank of California. Please review the Data Collection section of Article 2 for an explanation of why these companies were selected for analysis.

¹³ One respondent had previously been married to a man, although she did not explicitly identify herself as heterosexual. This respondent could neither be categorized as a coupled lesbian/queer woman or as a single mother by choice.

Between the fall of 2015 and spring of 2016, I conducted in-depth telephone interviews with 33 women residing in the United States who had gone through the process of selecting a sperm donor from an online sperm bank. Applying a modified version of Glaser and Strauss' (1967) framework for open, axial, and selective coding, I repeatedly analyzed transcripts from each interview to determine respondents' underlying beliefs about what makes a donor an ideal or undesirable candidate. In their interviews, clients discussed how they assessed and identified their ideal donor—often relying on mainstream knowledges regarding genetics and inheritance. When asked about their beliefs about genetics and inheritance, and which traits and aptitudes they believed to be heritable, clients expressed uncertainty but optimism about whether certain characteristics could be passed on to their children. Clients also described feelings of unease or conflict when identifying which men or which traits should be excluded from the sperm donor market. To cope with those feelings of unease, clients coped strategically, explaining that they would not engage in those practices “in real life” wherein couples meet face-to-face, get to know one another, and procreate in-person. They would also depersonalize the donor—noting that he is a means to an end, a supplier of materials that can provide the traits necessary for creating a healthy, intelligent, talented, successful child.

4.7 Identifying the “Fit” and “Less Fit”— Exercises in Individualized Eugenics

When clients of donor sperm first encounter online sperm donor files, they are presented with a donor pool that their chosen sperm bank markets as both exclusive and elite. The donors who make it through the sperm banks' extensive screening practices are (presumably) the best possible donors available. These men have been screened on a variety of measures including but not limited to: sperm health and quality, physical and mental health, medical background, genetic and communicable disease risk, educational attainment, and social indicators of aptitude and

success (Daniels 2006; Kroløkke 2009; Moore 2007; Schmidt and Moore 1998; Tober 2001).

California Cryobank (2019) offers a compelling image to depict this process (Figure 1). In describing their extensive donor qualification process, prospective donors are funneled and filtered through the various stages of screening. At the bottom of the funnel, a single man, “the best man,” remains victorious:

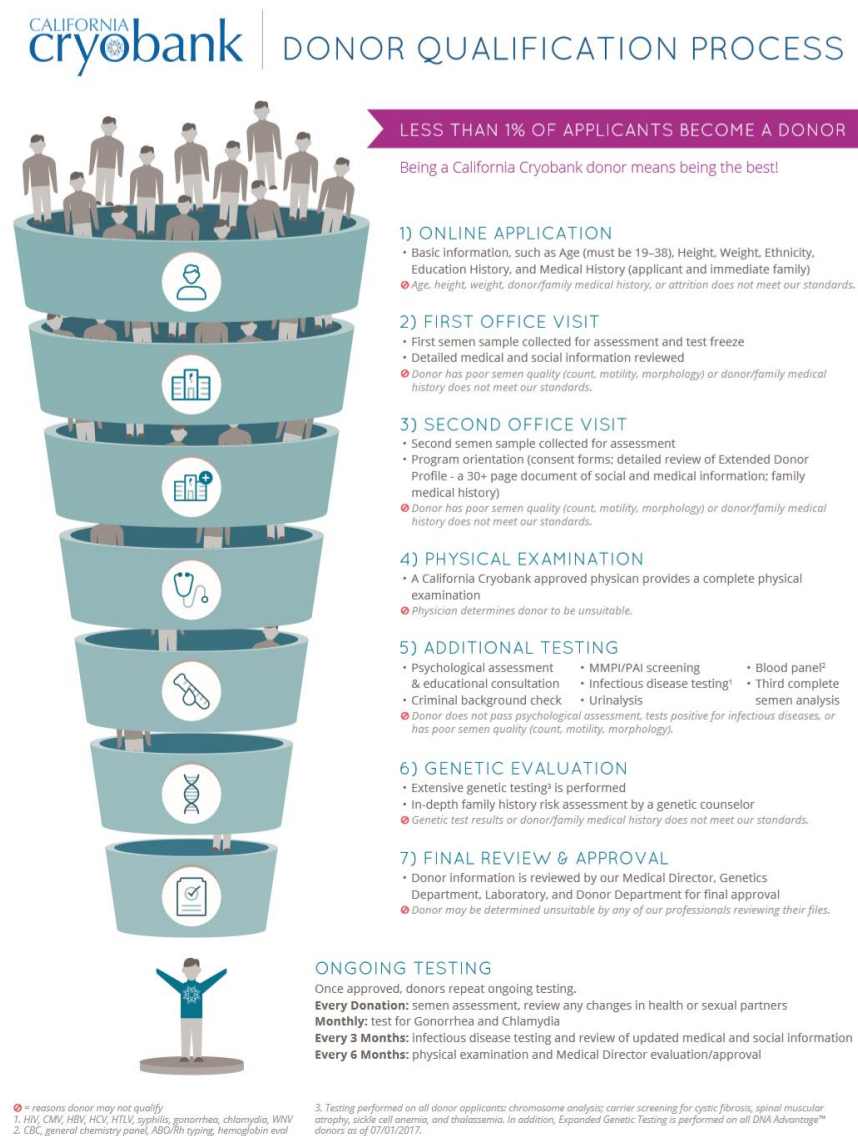


Figure 2. California Cryobank (2019), Donor Qualification Process

The image and description of screening services are meant to offer comfort and confidence to prospective clients. They are made to feel that no matter what donor they choose, he will be exceptional. Furthermore, and more importantly, clients expect that their chosen donor possesses traits that can be passed on to their offspring, ensuring the child will be both physically and socially dominant (Daniels 2006; Mamo 2005, 2010; Schmidt and Moore 1998).

However, clients of donor sperm *must* make a choice, and in many cases, they have dozens—sometimes hundreds—of suitable options. To efficiently choose, clients must begin winnowing down their options through the application of various “filters” and determinations. As has been documented by other researchers, clients of donor sperm initially start their search by applying filters related to race and appearance so that the resulting child will “match” herself, her partner, and her family (Hertz 2006; Jones, 2005; Mamo 2005, 2007; Nordqvist 2010, 2012; Ryan and Moras 2016). Beyond matching in this manner, clients must make more nuanced choices using the information at their fingertips: detailed medical histories and genetic information, donor education and program of study, career (realized or aspirational), hobbies, interests, and interactions with bank staff.

It is at this stage of the donor selection process that I document how clients of donor sperm engage in various *neoeugenic* practices (Daar 2017; Suter 2007). Presented with a donor pool of elite men who have already undergone systemic and eugenic screening by the commercial sperm banking industry and its affiliated experts, clients must further identify which of these donors are “fit” or “less fit” for the task at hand. Relying on mainstream knowledges about genetics and inheritance, as well as the specialized “expert knowledges” promoted by the sperm banking industry itself, clients assess and act. In doing so, they engage in individualized positive and negative eugenic practices, reifying rather than challenging the underlying

ideologies within historic and modern-day eugenics. Clients of donor sperm consistently and purposefully select donors with traits they believe will improve upon their prospective child's genetics, health, and overall quality of life as exhibited by Ashley's acknowledgement:

I have kind of a crappy family medical history, so we wanted to even them out. Family medical history was one of our biggest concerns because there is so much crap that goes along on my side. I feel like I have the worst genetics ever on so many levels, so I was really trying to improve my genetics. We would look at their health backgrounds. I have diabetes in my family. I've got heart disease in my family. I've got strokes in my family, so I try to avoid anything like that. So, I mean, we still tried to get the best – you know, the best health we could get.

In her analyses of lesbians using donor sperm, Laura Mamo (2005, 2010) documents the ways in which clients purposefully reflect on their own medical histories and genetics when identifying a suitable donor. These patterns were quite common across interviewees' discussions of the donor selection process. Such determinations are based on clients having both a basic understanding and an acceptance of knowledges regarding genetics and inheritance. Robin similarly articulates the importance of comparing the donor's genetic background with that of her partner, who carried their child:

I looked at what are the things about him that I would want his genetic code for, and then I looked at what were the things that, had I been able to be the babies' genetic parent, what would I have wanted to pass down? And then how could I stack the deck in our children's favor, because obesity is one of the things in my family and some other chronic health conditions and things, so I looked at how could I pass on what I wanted to pass on and give my child protective factors from other diseases and conditions that run in our family lines.

Interviewees' initial concerns with inheritance predominantly pertained to genetic or health-related diseases, disorders, or disabilities. In addition to highlighting diseases such as cancer, Cystic Fibrosis, or Alzheimer's, they also expressed concerns with the potential for passing on what they perceived to be heritable diseases such as addiction, alcoholism, depression, anxiety, and mental illnesses—particularly those leading to suicide. To prevent themselves or their

partners for passing on what they deemed to be poor genes or at minimum, the propensity for poor health, clients of donor sperm conscientiously select donors who do not share the same diseases or disorders in their medical or genetic backgrounds. Consequently, clients would also exclude donors *with* those traits, viewing the prospective pairing as having the potential to significantly increase the risk of inheritance in their future child. Even among the exclusive 1% of sperm donors (California Cryobank 2019; Fairfax Cryobank 2019), clients determine that many of the donors don't make the cut. While they may be "fit" for some, they are "less fit" or even "unfit" when considered on an individual basis.

Interviewees applied these same theories of inheritance to traits unrelated to health. After highlighting what she views as her family's health-related shortcomings, Ashley continued:

We also looked for someone who is athletic and coordinated to balance me out. And someone who is good at math, because I am not (laughs). I wanted someone tall, if I could have someone who didn't wear glasses, because I wear glasses. I was trying to look for someone – I mean, this is all so shallow, but like, I have very fine hair. I was trying to find someone who had thicker hair.

Mamo (2005, 2010) similarly documents the ways in which lesbian clients of donor sperm would base a donor's selection on how well he might off-set or balance out her own perceived inadequacies, both related and unrelated to health. During discussions with interviewees, ideal donor traits were almost always identified in direct response to their own (or their partner's) perceived flaws. The solution to these flaws was to counteract those traits and aptitudes—or lack thereof—by leveraging the donor's "opposite" (and "good") traits.

In addition to balancing out what they viewed as negative traits that they themselves carried, clients of donor sperm also attempted to amplify their positive traits. When a client possessed a trait or ability that she deemed both good and desirable, she would look for that trait or ability in a donor so as to increase the likelihood that her child would exhibit it.

Maureen: My secondary requirements were to be complementary with my own abilities and talents, so I wanted to find a donor that – for example, I'm horrible with math, horrible! Horrible at math! I hate it. I'm terrible, and I really wanted to find somebody who had some math skills, so I put math skills as one of the things I looked for. The other thing: I'm not athletic, not at all. I'm not interested in it. For us, exercise is walking, you know? So, I wanted to find somebody who was interested in athletics. And then I had a third one, which is I have a huge life passion, which is music. That's important to me, and so I thought I'd really love to find somebody, again, who shared that passion with me, so it was math, athletics, and music.

By applying simplistic understandings of inheritance and genetics wherein complex characteristics are transmitted in predictable patterns, clients of donor sperm hope to provide their prospective children with the skills and aptitudes they believe would help them be more successful in life. When asked why aptitudes in math or science were viewed as valuable in a prospective donor, Amber explained: “We want our children to be successful, so we’re trying to find someone that’s successful, whatever that measure of success is. Because, we want to give that kid every leg up possible, you know? Whether it’s because they’re tall or athletic, or good at math.” Danielle echoed those sentiments, focusing on how those skills could improve the quality of life for her daughter:

We always want our children to be better than we are, and if she happened to inherit those talents, and if math and science come more easily to her than they did to either of us, then that's something good that we've done for our child in selecting her donor, I guess. And if she doesn't inherit that, then that's fine, too.

Through these assessments and practices, clients of donor sperm actively attempt to pre-order and construct a customized child, with as many traits and aptitudes that could help that child be healthy and successful. In a biomedicalized industry that operates within a society that is entrenched with historic and ongoing systemic inequities, these practices not only commodify health, they commodify privilege. The accuracy of these loose applications of genetic “science”

here is irrelevant; clients of donor sperm make these choices because they believe it *may* work and if it does, their children *could have* an improved quality of life.

4.8 Well, Why Not?

During our conversations about their donor selections and who makes an ideal candidate, I asked clients to distinguish which traits they distinctly believed to be heritable and which were not. Although clients of donor sperm often acknowledge that traits such as personality, interests, or life aspirations may not be heritable (Scheib 1994; Scheib, Kristiansen, and Wara 1997; Tober 2001), interviewees held onto the possibility that those attributes *may* be heritable, referencing the complexities of nature versus nurture and that we (culturally and scientifically) still lack a full understanding of genetics and inheritance.

Christina: It's sort of like – we don't really know, but if it is – you know, I mean, even athleticism, right? I don't know if it's genetic or not, but if it is, I'd prefer him to at least get some athletic capabilities from the donor as well. I guess, you know, if any of this true is or if any of this could be passed down, then let's try and create a baby that might have the traits that we want this baby to have. I don't know. I mean, yeah. I mean, like, if I really think about it, it doesn't make any sense, right? Because if it's all social, then couldn't I just kind of impart that to the kid? But I guess we don't know. I mean, like, I haven't done the research, so I don't know. Like, I don't know if I care about animals and I'm compassionate because my parents did or because I saw it, you know what I mean? I don't know if it was in my genes or if it's in my upbringing.

While citing the ambiguity and complexities of inheritance, clients of donor sperm simultaneously remain optimistic that simplistic interpretations and applications of genetics—such as those outlined in Mendelian genetics—are accurate. Several clients explained that given the complexities, it was safer to just err on the side of caution. When discussing how she did not believe that hobbies or interests were necessarily heritable, Emily reflected, “Maybe it's just that we're not really clear how much is nature and how much is nurture, you know? I guess if you have your choice, why not – not take the chance?” Employing such thinking enables clients to

proceed in their donor selection process as if they have power and control—whether real or merely aspirational—to activate or prevent certain traits from presenting in their future children. Acknowledging that that control may be false, many clients of donor sperm choose to make their selections as a type of insurance policy that could potentially benefit and privilege their children (and families).

Online sperm banks provide vast and extensive donor profile information as a part of their marketing strategies. The more information they provide, the more they attempt to distinguish themselves from their competitors and the more they can charge clientele for those additional services and features. Online sperm banks rely on clients recognizing the diverse and expansive range of donor profile information as not only interesting, but pertinent to the selection process. More specifically, they want clients to think about how the donor could influence the end product: the resultant child. On a webpage advising clients on how to choose a sperm donor, Fairfax Cryobank (2019) explicitly advises potential clients that although we are still learning about the nuances between nature and nurture, genetics matters:

How much does genetic inheritance really matter in determining what kind of person one becomes? Optimizing the environment, broadly defined to include good nutrition, parental love, excellent educational opportunities, and more will of course help each child reach its full potential. But there is extensive evidence that this potential is heavily influenced by inheritance. The best proof comes from long-term studies of identical twins - who are genetically identical - but who have been separated near the time of birth and thereafter reared apart.

The fundamental conclusion from decades of research is that the life patterns, accomplishments, intelligence, and appearance of identical twin pairs, who in many cases never met again until very advanced ages, are amazingly similar. So, genetics matters a great deal in determining who we are and what we will become in childhood and adult life. Most scientists now recognize that intelligence is at least 50% determined by inheritance, and many would place that number closer to 70%. Such traits as musical ability, artistic talent, athletic aptitude, and many more are also partly genetic.

For this reason, we recommend that even allowing for the variability in inheritance of specific genes from biological parents, significant thought be given to choosing a sperm donor who has the qualities that one might like to see in one's child. There is no guarantee that a specific quality will indeed be expressed in the child, but there is a greater likelihood of it occurring than if this is not factored into the decision about which donor to use. This is why our Cryobank donor pool is very carefully selected not only to exclude detectable propensities to adverse traits but very importantly to include positive attributes widely desired by many parents.

In presenting such claims to clients of donor sperm, online sperm banks reify and legitimize their own marketing practices—particularly those related to upselling extensive donor profiles and the ever-present discourse of creating a perfect child. The narrative also attempts to reaffirm clients' sense of control in the construction of that child. Furthermore, it encourages clients of donor sperm to actively participate in the company's boutique-style selective breeding services. Through the banks' biomedical technoservices, clients are led to believe that they have the ability to craft a healthy, able-bodied, intelligent and talented child. Through the donor insemination market, consumers are encouraged to pursue and achieve health—for their children, for themselves, and for their families. Such marketing and consumerism exemplify what medical sociologists refer to as the biomedicalization of reproductive health and its affiliated practices (Clarke et al. 2003, 2010; Clarke and Shim 2011; Mamo 2005, 2010).

4.9 “It’s Ugly, But It’s True”

Several interviewees expressed a level of discomfort when walking through their donor assessment and selection processes, highlighting how their categorizations of donors made them feel superficial, shallow, or uneasy. Many of the interviewees described themselves as progressive, both politically and personally. When describing their processes of elimination and their subsequent identification of men who they deemed unsuitable, many felt conflicted. Cameron explains:

As far as health stuff, I don't know. This is the thing that was hard, right? Like this is the thing where the rubber met the road, when we were choosing sperm – this is where it got really hard for us, right? Because politically or ideologically or whatever you want to call it, philosophically, I believe that all types of bodies are worthy. Whether that body has, like, chronic illness or has a disability. But then, I wouldn't have chosen a sperm donor that had, say, you know, cancer all over his medical background. Since we could make the choices, we chose to try and avoid that, you know? If we were just, like, having sex to make a baby, we would just work it out. But we're not, right? We're crafting this child on some level, and so that's the thing that was really hard for me. I'm a disability rights advocate, but I think that it would be hard for me to choose someone who had, like, spina bifida or whatever. I imagine the people buying the sperm are not looking to, you know, use sperm that may have some genetic abnormality or whatever. Or that might lead to some sort of chronic medical issues and if I saw that a donor produced an abnormality, I would be less likely to choose that donor. It's ugly, but it's true.

Regardless of her personal views regarding all bodies having value and worth, Cameron acknowledges that given the option to choose, she would rather act in ways that could prevent the birth of a child with diseases or disorders. Even more, she would purposefully avoid choosing a donor if she believed that her prospective child might have an increased risk of inheriting a disease or disability. Noteworthy is the level of screening that has already taken place of the donors who are included in the candidate pool—they are unlikely to have chronic illness or diseases—although some do have common diseases such as cancer, heart disease, and Alzheimer's in their family histories. These typically are not “rampant,” but nonetheless present as no donor is truly “perfect” in terms of his health and genetic background (Tesene 2019). Indeed, sperm banks are now changing their screening practices to be more inclusive of men with genetic markers for diseases that are more common and cannot easily be transmitted to a child without a mother who also carries the same disease (Fairfax 2019; Tesene 2019). In identifying donors with more extreme cases as being potentially problematic, Cameron describes a situation that is unlikely to occur within the contemporary sperm banking market.

During these discussions, clients expressed significant discomfort with the underlying values in such practices. Some explained that the process itself was in line with eugenic ideology and practices. Despite those acknowledgements, interviewees also recognized that when given the option, they would act in ways that are consistent rather than contrary to eugenic practices.

Julia: It is really sad because it's almost, you're "cleansing" people, but I don't like to think about all of that because basically you're choosing. Selecting your population is scary if you think about that, but the idea – yeah, I do think that if you're already going to screen for it, and if you're going to have a chance to, I guess, procreate and choose a lot of characteristics of the person that's going to help you – you know, or the sperm that's going to help you do that. I'm sorry if that steps on toes and things, but that's what it is.

Some interviewees responded to this realization and its associated discomforts by explaining that they would never behave in such ways "in real life," as was the case with Sara: "The whole process is sort of surreal, and harsh. There were moments when I'm like, 'Fuck! This is an exercise in eugenics!' And it's both fascinating and disgusting that I'm picking people based on things that, if I were in love with a person with sperm, I wouldn't consider."

For most people, family planning does not involve a formal review of one's partners medical background and genetic tests. Nor does it entail having to conduct side-by-side comparisons of prospective partners while specifically considering what sort of child they might produce. Clients pointed to this fact when explaining their actions.

Heidi: When we meet someone, and we connect on a certain level, it's like, "Okay, you're not option number one and then there's another option behind door number two and door number three." It's like, "Okay, you're here. You're in front of me. This is happening." As opposed to, you know, donor selection. It's like, "Man, I have all these different options! Hm. Is this important to me?" "Hey, this other guy doesn't have that." You know?

Another strategy for managing feelings of discomfort was to depersonalize the situation and the donor, to distance themselves from the person behind the sperm. While acknowledging how the

process is significantly different with a partner, Vanessa also takes a pragmatic view of the donor's role:

I think the biggest thing is, essentially when you're choosing a donor, you are not, in fact, choosing a partner, a friend, someone you're going to have a relationship with. You are, in essence, choosing a genetic and medical history. Then, you know, what you're looking for is somebody with a relatively healthy genetic and medical history. So people with, you know, known genetic and metabolic disorders that can be passed on probably aren't good choices. Because that is what you're choosing at that point. You're not choosing the person. You're choosing what they bring genetically and medically to the equation, and while I would have no problem with the idea of somebody who has a known thing, knowing what their risks are, and deciding to have children themselves, I think, in terms of a donor, what you're looking for is, like, fairly clear medical history, good to go. Because, you know, you're choosing a different thing than when you're choosing a partner.

Those researching the donor insemination market and its presentation of sperm donors argue that sperm banks actively encourage clients of donor sperm to personalize the donor, to think of the man when making their purchase, not the specimen (Daniels 2006; Kroløkke 2009; Moore 2007; Schilt and Moore 1998; Tober 2001). They also identify the clients as viewing donor sperm in relation to the man, his individualism, and his humanity (Daniels 2006; Kroløkke 2009; Moore 2007; Schilt and Moore 1998). I find that when dealing with feelings of unease related to what they interpret as problematic (eugenic) values, clients instead view donors as just that: donors. No longer are they considering the humanity behind the semen; rather, they are considering his worth in terms of what traits—health, genetic, aptitudes, and interests—that he can transmit to a child.

4.10 Discussion

Daar (2017) argues that we have entered a new era of eugenics where authoritative governing bodies no longer need to enforce oppressive policies that seek to prevent “undesirable” populations from reproducing. Rather, the rapid advancement of reproductive

knowledges and practices—particularly those relating to human genetics—have led to the proliferation of *neoeugenics*. This new eugenic model is enacted at the individual rather than the institutional level whereby prospective parents participating in the contemporary reproductive market can make various choices regarding their offspring (Daar 2017). As medicine, technology, science, and industry coalesce into a hybridized biomedical market, individuals are increasingly treated as customers who must pursue health by consuming products and services (Clarke et al. 2003, 2010; Clarke and Shim 2011; Mamo 2010). It is within this context that clients of donor sperm make their donor selections. Although they make their selections as individual consumers, they are subject to powerful marketing and corporate-sponsored “medicalized knowledges” (Clarke et al. 2003, 2010; Clarke and Shim 2011; Mamo 2010). Much of that knowledge is embedded in evolving eugenic ideologies—grounded in the science of genetics and framed as health.

In this study, I document some of the ways that clients of donor sperm engage in eugenic practices at the individual level. Having accepted the technoscience behind the various medicalized products and services available, they reify rather than challenge eugenic values and practices. Using the unique form of family planning via donor sperm, clients of donor sperm engage in a form of selective breeding in which they attempt to pass on desirable (dominant) traits to their children. Clients of donor sperm, like most aspiring parents, want their children to be happy, healthy, and successful. They view the donor selection process as a way to stack the deck in their child’s favor—potentially providing them with the health, body, skills, and interests that will enable them to excel in a world that is rife with inequities. Within the contemporary sperm banking industry, individuals and families attempt to obtain these privileges through the power of purchase. They do so consistently and predictably—adhering to dominant ideologies

regarding what people and what bodies are worthy of reproduction. As such, the contemporary sperm banking industry and its affiliated reproductive markets succeed in where the early American eugenics movement failed: promoting and selling “good births.”

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5 CONCLUSION

In this study, I examine how the marketing and consumption of donor sperm perpetuates various forms of inequality. Employing qualitative content analysis of sperm bank marketing materials and interviews with 33 women who went through the process of donor selection, I examine how the contemporary sperm banking industry exists as a site wherein consumers attempt to construct children and families of privilege. Online sperm banks—commercial and non-profit alike—offer clients a customized consumer experience wherein individuals can plan their families by participating in the industry’s boutique-style selective breeding practices. Through the process of donor selection and evolving genetic screening and counseling practices, clients of donor sperm attempt to select traits of power and privilege—hoping that the children and families they produce will embody hegemonic values regarding race, health, ability, intellect, success, and family formation.

As medicine, technology, science, and industry coalesce into a hybridized biomedical market, individuals are increasingly treated as customers who must pursue health by consuming products and services (Clarke et al. 2003, 2010; Clarke and Shim 2011; Mamo 2010). Mamo (2010) further contends that the widespread acceptance of neoliberal ideology has increased the sense of individual responsibility in establishing and maintaining one’s own health. This belief has become paramount in shaping the reproductive market more broadly. Within this market, health is a commodity that individual consumers can and *must* pursue through ever-expanding customizable products and services (Mamo 2010). It is within this context that clients of donor sperm make their donor selections. Although they make their selections as individual consumers, they are subject to powerful marketing and corporate-sponsored knowledges that promote very specific notions of health, family planning, and the ideal child.

The fundamental purpose of this dissertation was to examine how sperm banks are marketing sperm *and* how those seeking to achieve pregnancy via donor sperm interact with and understand the donor profiles as they make their selections. My analyses focus on how various forms of inequality—such as white supremacy, hetero-patriarchy, and eugenic values and practices—are reproduced within the donor insemination market. I also sought to highlight how this industry markets various forms of inequality and how consumers, in turn, respond to, reinforce, and potentially resist those efforts. I found little evidence of clients of donor sperm resisting those hegemonic value systems. Not surprisingly, I also documented how the industry itself is only increasing its efforts to market those values in order to cash in on consumer fears of reproductive risks and the potential for disease, disability, and disadvantage.

In “White Like Me: The Propagation of Privilege Among White Women,” I document the persistence of white invisibility and its associated privileges as it occurs among white women clients of donor sperm. Even within the context of explicit conversations about whiteness, racism, and oppression, most white women fail to acknowledge how they specifically benefit from whiteness and white supremacy. However, these women display complex, critical, and conscious understandings of race; they recognize that race is a system of oppression and privileges wherein non-whiteness functions as a potential disadvantage. They are also aware that children of color and transracial families have struggles that are not imposed upon white people or racially homogenous families. Rather than face the potential stigma, discrimination, or mistreatment that is associated with racism, they choose to maintain their racial privilege and pass it on to their children. In choosing a white donor, they conform to the dominant narrative of what constitutes a family: a racially homogenous family unit, seemingly connected by biology

via heterosexual sex (Hertz 2006; Nordqvist 2012; Quiroga 2007; Roberts 1997; Ryan and Moras 2016).

In “Risky Business: Marketing Risk and the Expansion of Genetic Screening,” I examine how genetic screening and genetic counseling are increasingly applied and promoted within the U.S. sperm banking industry. Relying on a discourse of risk and supported by an increasingly biomedicalized reproductive industry, online sperm banks have expanded their services beyond the scope of offering mere donor sperm. By leveraging the rapid advancement of genetics-based knowledges and reproductive technologies, online sperm banks upsell existing products such as technosemen while reaching new avenues of revenue through client-based screening and genetic counseling services. While sperm banks continue to place an emphasis on sperm itself as risky, clients of donor sperm—predominantly single women and lesbian couples—now encounter marketing materials that frame these aspirational mothers-to-be as potentially “at-risk.” Commercial sperm banks identify the client as posing a significant threat to her future pregnancy and offspring, simply by being who she is at the genetic level. Furthermore, the sperm banking industry encourages clients to fear the countless risks posed by communicable and heritable diseases. It is only through the application of innovative screening procedures and the dedication of scientists and medical experts—in the employ of these companies—that clients of donor sperm can rest assured that their hopes of producing a healthy child can be achieved.

Finally, in “The Good, The Bad, and The Ugly: Exploring the Eugenic Implications of Sperm Donor Selectivity,” I critique how clients of donor sperm, supported by dominant beliefs about genetics and heritance, reify eugenic values and practices through their individualized donor choices. In identifying the characteristics of potential donors that they deem to be desirable or undesirable, they reinforce ideologies similar to those once promoted by advocates

of the early American eugenics movement. Although the individual choices of clients of donor sperm are a far cry from authoritarian, state-sponsored sterilization and institutionalization programs (Daar 2017; Suter 2007); the underlying ideologies about who should be left out of the reproductive market are promoted at the cultural level, often by powerful institutions that control the production of reproductive knowledge (Hubbard 2006). Using the unique form of family planning via donor sperm, clients of donor sperm engage in a form of selective breeding in which they attempt to pass on desirable (dominant) traits to their children. Clients of donor sperm, like most aspiring parents, want their children to be happy, healthy, and successful. They view the donor selection process as a way to stack the deck in their child's favor—potentially providing them with the health, body, skills, and interests that will enable them to excel in a world that is rife with inequities.

The thread that weaves these three articles together is one of privilege, power, and purchase. Online sperm banks capitalize on consumer fears of not only reproductive risk but risk of disadvantages and oppressions. Our society is one that is rife with complex and intersecting oppressions and inequities (Crenshaw 1991), and in their interviews, clients of donor sperm recognize and understand how those potential inequities could negatively influence themselves, their children, and their families. To offer protection from certain forms of discrimination and oppression—such as white supremacy, hetero-patriarchy, ableism, and classism—they make choices that they believe will improve their child's quality of life and make their own lives easier.

Clients of donor sperm use the donor selection process and emerging genetic screening and counseling services in order to “stack the deck” in their child's (and their own) favor. To have a child who is white is to have a child who is racially privileged. To have a racially

homogenous family that is also white upholds white supremacist hetero-patriarchal standards of what a family “should look like.” It also provides child and family with a lifetime protection against racial discrimination. To have a child who is physically, mentally, and genetically “healthy,” is to have a child who is unburdened by potential diseases, disorders, or disabilities—no doubt offering a variety of advantages and privileges throughout one’s life. This is particularly true for a society such as ours wherein significant barriers prevent access to affordable, quality healthcare. Similarly, to aspire to craft a child that exhibits “ideal” genetics, physical and mental health, intellect, and aptitudes for success is to aspire for a life of power and privilege.

Within an industry that commodifies health and privilege in this way, is the potential for exacerbating existing and producing new inequities and forms of oppressions. The validity of the sperm donor selection process to truly deliver what sperm banks promote—the ability to produce the “best possible child” with the “best possible donor”—is unconfirmed. However, the *idea* that such a possibility is a reality makes possible a market that is in the business of buying and selling power and privilege. The purpose of this research is not to critique clients of donor sperm for making choices that are both expected and encouraged in our society. However, the fears and concerns articulated by clients of donor sperm are reactive to the ubiquitous and powerful ideologies that uphold oppressive systems of inequality. In internalizing these values and acting in ways that uphold rather than challenge those beliefs, clients of donor sperm contribute to and ultimately reproduce the powers and oppressions built into those systems.

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APPENDICES

Appendix A: Select Characteristics of Sample

Table 1. Selected Characteristics of Sample

	Frequency	Percent
Gender (Woman)	32*	96.96
Race (Self-Identified; Open-Ended Question)		
White	29	90.63
Multiracial	1	3.12
Asian	1	3.12
Hispanic	1	3.12
Age Group		
25 – 29	1	3.12
30 – 34	10	31.25
35 – 39	9	28.12
40 – 44	6	18.75
45 – 49	4	12.50
50 – 55	2	6.25
Education		
Some College	1	3.12
Associates Degree	1	3.12
Bachelor's Degree	10	31.25
Master's Degree	14	43.75
Doctorate	6	18.75
Sexuality		
Heterosexual	7	21.21
Lesbian	19	57.58
Bisexual	4	12.12
Queer	2	6.06
Other	1	3.03
Relationship Status (check all that apply)		
Single	7	16.28
Never Married	5	11.63
Married	16	37.21
Cohabiting	5	11.63
Divorced	2	4.65
Separated	2	4.65
Other	6	13.95
Client Type		
Queer/Lesbian Women	24	72.7
Single Mothers by Choice	9	27.3

**One of the 33 interviewees did not complete the questionnaire and demographics information*

Appendix B: Interview Guide

Interview Questions

- Can you tell me about how you decided to pursue donor insemination to achieve pregnancy? (What was the process/journey like for you?)
- Why did you choose DI over other family planning options?
- Have your efforts at achieving pregnancy through DI been successful?
- (Where applicable) Who in the relationship is attempting to become pregnant?
- (If applicable) In the event that DI does not work, do you think you will consider other forms of ART? Which ones? Why or why not?
- (If applicable) Would you consider using adoption? Why or why not?
- Why did you decide to use a sperm bank instead of using a known donor?
- Did you at any point consider using a known donor? Why or why not?
- Broadly speaking, what sort of men do you think make the best sperm donors?
 - What qualities should they possess?
 - Why are these traits important?
- What sort of men should sperm banks actively seek out for the purpose of sperm donation?
 - Can you explain why these men would be ideal sperm donors?
- Can you tell me what your initial requirements were for a sperm donor?
- What was your overall impression of the donors who were available via your chosen sperm bank(s)?
- Were you happy with the types and number of donors available? Why or why not?
- Of the donor information made available to you, which information did you find the most important? Least?
 - What information was the most/least useful in making your decision?
- **Can you describe for me, in detail, how you went about making your donor selection? What was the process like for you?**
- How do you think the process has been for your partner? (If applicable)

- Did you and your partner have any trouble agreeing on a donor?
 - If so, can you explain to me what the disagreement was about and how you came to a consensus?
- In what way did you consider the non-biological contributing partner when making your donor selections?
- Has the non-biological contributing partner had any struggles with the process of donor selection? Can you describe these for me?
- Is your donor open or anonymous? Can you discuss why you (and your partner, if applicable) chose to have an open/anonymous donor?
- Can you tell me about the donor(s) that you ended up choosing?
 - What is he like? What sort of person do you think he is?
 - On what basis did you consider them an ideal donor?
 - Why did you select this/these donor(s) over the others?
 - Is there anything special about this donor that made you just know that “he was the one”?
- What traits/characteristics were the most important to you when making your selection?
 - Physical? Which most important and why?
 - Personality? Which most important and why?
 - Social? Which most important and why?
 - Educational/Career based traits?
 - Health, Intellect, Etc. (those mentioned by participant)
- Of the traits you mention, can you tell me which you believe to be distinctly inheritable? (Passed on genetically versus primarily due to social environment?)
- Of those traits you believe to be non-inheritable, why do you think they made an impact in your selection process? (If applicable)
- What role, if any, did race play in your experiences with donor selection?

FAMILY/PATERNITY

- What does family mean to you?
- What makes a family?
- What makes someone a parent?
- What meaning do you think the donor has to you and your family? How does/doesn't he fit into your family?
- How important is a biological connection in shaping a family?
- Speaking in general, what do you think makes someone a good father?
 - Did you take these factors into consideration when choosing a donor?
- What do you think makes someone a good mother?

How do you think the donor profiles shaped your selection criteria?

- For instance, was there a difference between the time when you first began looking for a donor versus when you were immersed in the sifting through the different sperm donor profiles?
- **Once you began reviewing donor profiles, did you notice any new emergent criteria for a donor?**
- Why do you think these factors became important to you in making your selection? (if applicable)
- Do you think your interaction with bank staff had any impact on your donor selection? If so, how?

If we think about marketing and advertising and sperm banks as companies that are selling consumers a product, what values and messages would you say they are marketing to consumers?

- How do you think the bank you used wanted you to think about the donors you chose from?
- How do you think the bank you used wanted you to think about the donors in terms of being men?
- What kind of men were they presented as?
- How would you define masculinity?
- Do you think their masculinity was emphasized in any particular way? How so?
- How do you think the bank you used wanted you to think about family?
- How do you think the bank you used wanted you to think about paternity?
- What other values do you think were being marketed to you?
- Do you agree with the values being promoted by the sperm banks? Why or why not?
- Is there anything about these messages or values that you don't like or disagree with in any way? What are those? Why don't you like them?

Appendix C: Interviewee Questionnaire

INSTRUCTIONS: Thank you for agreeing to participate in this study. Your honest thoughts and opinions regarding your donor selection preferences are requested and encouraged. As indicated in the informed consent, all questionnaires will remain confidential and anonymous, including to the researchers of this study. To promote anonymity, the researchers will access the questionnaires ONLY when all respondents have completed and submitted their questionnaires. No identifying information will be attached to the questionnaires.

Please fill out the following information as requested, either by clicking the appropriate category and/or writing in your response.

Age:

Sex:

☐ Male

☐ Female

☐ Other (Please indicate):

Gender:

☐ Woman

☐ Man

☐ Transgender

☐ Genderqueer

☐ Other (Please indicate):

Sexual Orientation:

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Other (Please indicate):
-

Current Relationship Status (Check all that apply):

- Single ☐
- Never Married ☐
- Married ☐
- Cohabiting ☐
- Divorced ☐
- Separated ☐
- Other (Please indicate): ☐
-

Race:

Highest Level of Education Obtained:

Area of Study (if applicable):

Occupation:

Household Income (Approximate):

Religion:

Political Affiliation:

- ☐ Republican
- ☐ Democrat
- ☐ Independent
- ☐ Other (Please indicate):

Please mark the appropriate response for each of the following statements. Make sure that your responses accurately reflect the individual statements presented to you.

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
I would prefer a donor who is a nice person.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important that my donor have a sense of humor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I want a donor who is or would be a good parent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who cares about the same social issues that I care about.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
It is important to me that the donor I choose have the same sense of values and morality that I do.					
I would prefer a donor who is the type of person with whom I could be friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would rather choose a donor who is the type of person with whom I could see myself in a romantic relationship.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be less likely to use a donor who has a different political affiliation than me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important to me that the donor I choose be someone who is very athletic.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The donor I choose must have above average mathematical skills.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who nurturing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who has strong communication skills.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important to me that the donor I choose be financially successful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spatial reasoning skills are not important to me in selecting a donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important to me that the donor I choose have a strong work ethic.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Donor artistic ability is not important to me in selecting a donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who is empathetic.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who is talented musically.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is not important to me that the donor writes well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who has strong critical thinking skills.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cooking skills are not important to me in selecting a donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who has strong mechanical skills.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being well-traveled is not important to me in selecting a donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who is shorter than 5'8".	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who is between 5'8" and 5'10" tall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who is between 5'10" and 6'0" tall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who is between 6'0" and 6'3" tall.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I would prefer a donor who is taller than 6'3".

Please mark the appropriate response for each of the following statements. Make sure that your responses accurately reflect the individual statements presented to you.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I would use a donor who is White.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who is Black.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who is Asian.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who is Latino.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who is multi-racial.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a Hispanic donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a Jewish donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important to me that the donor I choose went to or is currently going to college.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who has more than a college education.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would rather use a donor who went to or is currently going to an Ivy League college.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religious affiliation is important to me in selecting a donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a Christian donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a Muslim donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be less likely to use a donor who identifies as an atheist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who is spiritual but not religiously affiliated.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who identifies as heterosexual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who identifies as a gay man.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would prefer a donor who identifies as a bisexual man.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would rather use a donor who is working class.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would rather use a donor who is middle class.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would rather use a donor who is upper class.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is important to me that the donor I choose is the same race/ethnicity as me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
It is important to me that the donor I choose is the same race/ethnicity as my partner.					
I would be less likely to use a donor who dropped out of college.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is not important to me that the donor I choose completed high school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who had a non-inheritable physical disability.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would use a donor who had a non-inheritable mental illness.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be less likely to use a donor who had a different religion than me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual orientation is not important to me in selecting a donor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for your participation in this study. If you have any questions or concerns about the study or this questionnaire, please contact the Student Investigator Megan Tesene at mtesene1@gsu.edu or the Faculty Advisor Dawn Baunach at dbaunach@gsu.edu.

Appendix D: Informed Consent

Georgia State University
Department of Sociology
Informed Consent

Title: “Sperm Sells: An Analysis of the Marketing and Consumption of Donor Sperm”

Principle Investigator: Dawn Baunach

Student Principle Investigator: Megan Tesene

I. Purpose:

You are invited to participate in a research study. The purpose of the study is to explore the online sperm donor selection process. You are invited to participate because you indicated that you have gone through the process of sperm donor selection from an online sperm bank. Approximately 30 to 50 participants will be recruited. Participation will require about 1-2 hours of your time. The study involves an interview and a brief questionnaire.

II. Procedures:

If you decide to participate, you will take part in a 1-2 hour, audio-recorded interview with the Student Investigator. The interview will focus on your experience with the donor selection process. Questions about how and why you went about making your sperm donor selections will be discussed. The interview will take place in- person, over the telephone, or through video chat.

You will also be asked to complete a brief questionnaire regarding your donor selection preferences. The questionnaire should take no more than 10-15 minutes. If you take part in a telephone or video chat interview, you will receive a link to an online version of the questionnaire. Your responses will remain anonymous to the researcher. If you participate in an in-person interview, a physical copy of the questionnaire will be provided. It will be completed anonymously and out of view of the Student Investigator. When completed, you will seal the questionnaire in an envelope and hand it to the researcher. The researcher will access the form **only when all study questionnaires are submitted.**

III. Risks:

It is possible that being in this study may cause you minimal discomfort or anxiety. For instance, if you had or are currently having a negative experience with the sperm donor selection process, you may feel emotional. The researchers will attempt to reduce this risk. If you experience emotional or psychological stress as a result of participating in this study, please inform Megan Tesene. She will refer you to the appropriate national support services as well as resources that are located near your city of residence. You will be responsible for any costs for treatment.

IV. Benefits:

Participation in this study may or may not benefit you personally. Possible benefits include the chance to explore and reflect on your own experiences. Overall, we hope to learn about client experiences with the sperm donor selection process. We also hope to add to the growing body of literature on donor insemination and reproductive technology.

V. Voluntary Participation and Withdrawal

Participation in research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop at any time. Whatever you decide, there will be no negative consequences.

VI. Confidentiality

We will keep your records private to the extent allowed by law. Megan Tesene and Dawn Baunach will have access to the information you provide. Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP)). We will use a pseudonym rather than your name on study records. The information you provide will be stored in a locked file cabinet and/or password- and firewall-protected computers. Only the Principle and Student Investigators will have access to these.

All audio recordings will be recorded on a digital recording device. All recordings will be transferred and stored on a password- and firewall-protected computer. The Principal and Student Investigators will have access. Recordings will be deleted from the digital recording device once they are transferred to the password- and firewall-protected computer. Recordings may be sent to a third-party company for transcription purposes. Third-party transcribers are bound by confidentiality and will only have access to your first name, state of residence, and occupation. Audio recordings will be destroyed immediately after transcription.

The researchers will use a code sheet to store your contact information (email, usernames, telephone numbers, etc.). To ensure privacy, the code sheet will be stored in a locked file cabinet, only accessible to the investigators. It will be kept separate from any study data. Upon completion of data collection, all identifying information will be stripped from the study data. For example, an email address provided to indicate a willingness to be interviewed will be removed. Your name and other facts that might point to you will not appear when we present this study or publish its results. Findings will be summarized and reported in group form. You will not be identified personally.

VII. Contact Persons

If you have questions, concerns, or complaints about this study you may contact the investigator, Megan Tesene at 404- 413-6500 or mtesene1@gsu.edu. You may also contact the faculty advisor, Dawn Baunach, at 404-413-6500 or dbaunach@gsu.edu. Call Susan Vogtner in the Georgia State University Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu if you want to talk to someone who is not part of the study team. You can talk about questions, concerns, offer input, obtain information, or suggestions about the study. You can also call Susan Vogtner if you have questions or concerns about your rights in this study.

VIII. Copy of Consent form to Subject

We will give you a copy of this consent form to keep for your records. If you are willing to volunteer for this research and be audio recorded, please sign below.

Participant

Date

Principle Investigator/Research Obtaining Consent

Date

Appendix E: Recruitment Flyer

Share Your Story!

Have you selected a sperm donor using an online commercial or non-profit sperm bank?



Are you at least 18 years old and have gone through the process of selecting a sperm donor through an online sperm bank?

Study Coordinator: Megan Tesene
Research Institution: Georgia State University

PARTICIPATION INCLUDES

- * An interview, approximately 1-2 hours
- * Either in-person, over the phone, or via Skype or FaceTime
- * A brief questionnaire regarding your donor selection preferences

Contact mtesene1@gsu.edu for additional information.

Figure 3. Recruitment flyer

Appendix F: Donor Profile Quota Sampling

To have a racially diverse sample to analyze, I will select an equal number of donors from each racial group (White, Black, Asian, Latino, and Multi-Racial). I selected 5 donors of each racial group from the each of the individual sperm banks (California Cryobank, Fairfax Cryobank, the Sperm Bank of California, and Xytex Sperm Bank).

California Cryobank

White—5
Black—5
Asian—5
Latino—5
Multi-Racial—5
(25 Donors)

Fairfax Cryobank

White—5
Black—5
Asian—5
Latino—5
Multi-Racial—5
(25 Donors)

The Sperm Bank of California

White—5
Black—5
Asian—5
Latino—5
Multi-Racial—5
(25 Donors)

Xytex Sperm Bank

White—5
Black—5
Asian—5
Latino—5
Multi-Racial—5
(25 Donors)

100 Total Donors (or until I reach theoretical saturation)

Appendix G: Donor Profile Quota Sampling

Demographic Information

- Age
- Race/Ethnicity/Ancestry
- Religion
- Education
 - Area of study _____.
 - Ivy League (Yes / No)
 - Location (if indicated) _____.
- Occupation
- Parental Occupation & Education (if available)

Physical

- Height
- Weight
- Body Type
- Hair type: volume & texture
- Skin Complexion
 - Fair
 - Medium
 - Dark
 - Other

Cost (per vial) _____

Donor Type (Open or Anonymous)

Broader Concepts to be considered (via Masculinity & Intersectionality lenses)

Emergent themes and categories pertaining to:

Success

How described?

Financial Position Indicated? _____

Intellect

How described?

Drive/Motivation

How described?

Skills/Talents

- Artistic (Yes / No)
- Musical (Yes / No)
- Mechanical (Yes / No)
- Mathematical (Yes / No)
- Writing (Yes / No)
- Other (Yes / No)

Hobbies

(Traditionally masculine / Traditionally Feminine / Neutral)

Not Skilled—In what areas do donors indicate they are not skilled?

Athleticism

- Level Indicated: _____
- Type/Sports: _____

Appearance (Looks/Attractive)

As described by staff?

Personality Type

- How described by self? _____

- How described by staff? _____

Character

(How described?) _____

Personal Ethos/Philosophy

“Family Man” (Exact Phrasing) (Yes / No)

How Described/Indicated?

Already a Father? (Yes / No)

“Good Father” (Currently or Potential to Be)

How Described/Indicated?

Traits He Would Like to Pass on (if indicated):

“Work Ethic” (Exact Phrasing) (Yes / No)

How described?

Occupation Type (Traditionally Masculine/ Traditionally Feminine / Neutral Occupation)

Position: _____

Strength (If present, how are each conveyed?)

- Physical:
- Mental:
- Emotional:
- Character:

Progressiveness

How Described/Indicated?

Sensitivity (If present, how conveyed?)

- Caring
- Loving
- Nurturing
- Emotional
- Empathy
- Concerns of Social Issues

Is sexual orientation implied in any way? (Yes / No)

How Described/Indicated?

“Passionate” (Stated or Indicated)—(Yes / No)
How Described/Indicated?

“Romantic” (Stated or Indicated)—(Yes / No)
How Described/Indicated?

“Logic” or “Rationality” (Stated or Indicated)—(Yes / No)
How Described/Indicated?

“Scientifically-Minded” (Stated or Indicated)—(Yes / No)
How Described/Indicated?

ADDITIONAL EMERGENT CATEGORIES/THEMES: